Public Health Report Finland 1996

by
the Council of State of Finland to the Parliament
on the present situation and developments
in public health

MINISTRY OF SOCIAL AFFAIRS AND HEALTH
Helsinki 1996

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FINLAND 1996

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THE COUNCIL OF STATE OF FINLAND
TO THE PARLIAMENT
ON THE PRESENT SITUATION AND
DEVELOPMENTS IN PUBLIC HEALTH

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Public Health Report - Finland 1996

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The Public Health Report Highlights Successes and Challenges

The purpose of the Public Health Report is to give a compact overview of the prerequisites for the health of the Finns and their actual state of health, as well as of the major health challenges and trends. It does not try to cover all aspects of public health. It seeks to pick up for discussion those developments that we in Finland are proud of and those we feel that we need to work harder on. Despite its name the report is future-oriented rather than just a description of the past.

One of the success stories is the 60 % decline in the heart disease mortality since 1970. The decline highlights how systematic work on all aspects of a public health problem can result in major health gains. Cardiovascular diseases are multifactorial in origin and therefore no single measure is enough to combat them. A change towards healthier eating habits, a decline in smoking among men, and improvements in the treatment of hypertension and acute heart situations have all been essential.

Another success story is the improvement of the dental health of children. This is due to improved preventive dental care, use of fluor, improved family practices in toothbrushing and the use of xylitol in chewing gum and sweets. Again, this highlights the need for multisectorial action and diverse measures needed. Finland will perhaps be the only European country to achieve the targets of Europe Against Cancer and WHO in reducing the cancer mortality. AIDS cases are relatively few and there are no signs of the situation getting worse.

The success stories encouraged us also to study the dark side. Why is the number of deaths from accidents higher than in our neighbouring countries? What is behind the surge in the frequency of diabetes in children? Why does alcohol use cause a disproportional number of accidents and deaths in young men? What should be done in order to improve mental health?

Of the problems picked up for immediate attention and action perhaps the most alarming is the continuing health divide in the population. The population groups that are less well off, at a risk of social exclusion, are also disadvantaged in health terms. For example, unemployment is in practice often a health hazard even if it not necessarily needs to be.

By putting forward these unsolved public health problems with the success stories we hope to stimulate an active, open and solution-seeking discussion. As the solutions are very seldom confined to the health sector, the involvement of the public, non-governmental organisations, politicians, all departments of the Government and also businesses is needed. As a first step we would like to see a good debate in Eduskunta, our parliament.

The report pays much attention to the health effects of measures carried out by all branches of the public administration. The chapter detailing the measures administrated by other ministries than that of health is surprisingly large. It was gratifying and interesting to see that all the other ministries came up with an impressive list of and concern for health issues as detailled in this report. - We don't expect the interaction between the administrative branches to end with the Public Health Report. In the future we will deepen our analysis of the health effects of non-health sector measures.

The Ministry of Social Affairs and Health cannot tell other administrative branches how they should conduct their business. Rather, the health sector attempts to advance knowledge about public policies' health and social effects. The Ministry will also provide methodologies for evaluating these effects. We will try to put "healthy public policies" into action.

The Report ends with a chapter setting out the scene for action in the near future. The headlines describe the main interest areas in the coming two to four years. They include equity in health, the health of the young, the promotion of health and functional capacity, the development of health services, strengthening the national health policy and international interaction. The Ministry of Social Affairs and Health will work hard to get the suggestions thoroughly discussed and adopted by all sectors of society.

Finland has benefited from the active international discussion on public health policy. Our national development has been very much shaped by the Health for

All process that has taken place within the World Health Organization and been fostered by the WHO. The overall Health for All policy formulation, in particular, has followed the WHO model.

In Finland, the role of all the sectors of society in building healthy environments has been recognized for a long time. Changes in the social and physical environment have been a key part of the health policy. In 1995, the European Commission published a report on health protection requirements in other sectors of the Community than health. The Commission's report encouraged us to systematize our approach by including a similar exercise into the Public Health Report.

For a small nation, international cooperation and exchange are vitally important. By publishing this shortened international version of the Finnish Public Health Report we want to share our experience with other countries. We believe that there are many important lessons to be learned. One of the most remarkable features of the Finnish situation is the broad consensus on our health policy. Finnish scientists and research projects, such as the North Karelia project, have produced a solid scientific foundation for the policy. The policy-makers have created its practical implementation. The public health leaders both in the public and the non-governmental sector have secured a broad public support.

Ms Terttu Huttu-Juntunen
Minister for Social Affairs and Health

1.

PURPOSE AND CONTENTS OF THE PUBLIC HEALTH REPORT

Since 1987, the Government has been giving a report to the Parliament on the developments in intoxicant abuse in order to intensify the relative follow-up and planning (Act 254/87). The report has included information on the development of the intoxicant abuse situation as well as on the measures and plans aiming at the prevention of the related problems. The report has also contained a report by the Alcohol Company on the developments in the alcohol situation. The Ministry of Social Affairs and Health has compiled its annual report in collaboration with the Ministries of Education, the Interior, Finance, Justice, Trade and Industry, Labour, Transport and Communications and the Environment.

In its statement, given in 1994 and related to the 1992 intoxicant abuse report, the Committee for Social Affairs and Health of the Parliament stated that the report should be comprehensive, future-oriented as well as written in collaboration with the various sectors of administration. In 1995, the Parliament adopted the Government proposal whereby the report on intoxicant abuse will no longer be written but a more extensive report on the situation and development of public health will be published instead.

The Public Health Report Act (1238/95) prescribes that the Council of State shall give a biannual Public Health Report to the Parliament, describing the situation and development of public health. The Ministry of Social Affairs and Health compiles and presents the report once it has obtained the necessary information from the other Ministries. The first Public Health Report will be given in 1996. The said Act abrogated the Act on the Report on the Intoxicant Abuse Situation (254/87). No report on the intoxicant abuse relative to the years 1994 and 1995 will thus be given.

The purpose of the Public Health Report is to give a compact overview of the prerequisites and actual state of health of the Finns, as well as of the major health challenges and trends. The report does not intend to cover all aspects of health but to highlight the principal challenges and potentials in the foreseeable future.

The report will be accompanied by a more comprehensive volume on the public health situation published by the National Public Health Institute, as well as by the welfare and health service overview published by the National Research and Development Centre for Welfare and Health. These reports written by the best experts in their fields have been used as the basic material for this report. In addition, all Ministries have written a report on the recent health-affecting measures taken in their own sectors of administration. The operations related to the foreign affairs administration are, however, not included in this report. The overview of the health-affecting measures taken by the various sectors of administration, as well as the European Commission's corresponding report by each Directorate General, are of pioneering importance.

The Public Health Report concludes by presenting some principal challenges for the immediate future. The future-oriented part covers a period of 2 to 4 years because the report will be given every two years. In practice, the operative guidelines set by the Public Health Report have a perspective to the end of this century.

The principal conclusions of the Public Health Report are grouped under six headings.

1. Promotion of equity in health
2. Promotion of health among the young
3. Improving the population's functional capacity
4. Development of the service system
5. Coordination of public health policy
6. Strengthening of international cooperation

The Public Health Report will be discussed by the Committee of Social Affairs and Health of the Parliament. The discussions will provide the Government with information as to how the Parliament evaluates the successfulness of health policy, and it will give guidelines for its future development. The report and its parliamentary discussion also aim at opening health policy for public debate. Service production has been decentralized while national control has reduced. The information on the public health and service system situation as well as on the disparities between different regions and population groups will help the municipalities and other operators to modify their health policy towards a unified national line of action.

2. Prerequisites for Health and Health Policy Environment

2.1 Population

The Finnish population structure has undergone a rapid change. As a consequence of the population changes, approximately 64 % of the inhabitants live in urban areas. Due to internal migration in Finland, the population in the Uusimaa province has increased whereas a correspondingly smaller share of the people live in the eastern parts of the country. The share of the elderly is in continuous growth, and in 1994 the population of the over 60s accounted for 14 % of the population. Immigration to Finland has been very modest, and the number of refugees is very small compared to other West-European countries.

In the next few years, the population age structure will be characterized by the large age groups born in the immediate post-war years. As these age groups grow older, the whole population is aging. This development is further emphasized by the present relatively low birth rate. The share of the over 65s of the entire population is expected to grow from the present 14 % to almost 24 % by the year 2030. The growth will be particularly rapid in the 2010s as the large post-war age groups turn 65. Life expectancy of men is expected to be about 74 years and that of women almost 81 years by the first decade of the new millennium.

2.2 Physical environment

Environmental factors still constitute one of the major reasons causing cancer, allergies, asthma and other respiratory diseases. However, their effect is probably smaller than that of life-style factors. Exact causal relationships are not known as people are exposed to various environmental factors simultaneously and it is difficult to separate the impact of one individual factor from that of other environmental or life-expectancy factors. Furthermore, the concentrations of the environmental risk agents are low, and their impact on cancerous diseases is seen only after a long period of time. On the other hand, the environmental impacts on population are increased by the fact that a great number of people are exposed to them.

The major short-term environmental health problems in Finland are related to inside air and drinking water quality, exposure to radon and the effects of traffic in densely populated areas. In addition, the importance of certain aspects has not yet been clarified (e.g., the possible effects of the dioxins and PCB in the Baltic fish).

The most important preventive measures concerning environmental health impacts are related to community planning. Traffic, housing and commerce should be regionally separated, traffic emissions should be decreased or at least their increase be contained, and the time spent in traffic should be shortened. Most of the indoor air problems can be eliminated by developing building and restructuring technologies.

2.3 Development in social policy

The essential elements of the development in social policy over the last few years can be summarized in the following observations:

- Unemployment has become a serious problem, and especially the increased long-term unemployment has been reflected in many ways in the foundations of social security.
- Related party to unemployment, subsistence problems have become more acute and the number of persons receiving living allowance has increased.
- As a result of the cuts made, the distribution of social security in the various population groups has changed, the most disadvantaged persons constituting the object of special concern.
- Welfare and health services have undergone a restructuring reform, the essential characteristic of which is that the services provided inside institutions have been replaced by community or non-institutional services.
- The insufficiently developed community services have created new problems, including those encountered in mental health care and the work with the intoxicant abusers.
- The above is severely overshadowed by the problems in the social welfare funding principles.

2.4 Living conditions

The level of education of the population has continued to rise. The share of the persons who have received only the basic education is becoming smaller, being 40 % for males and 46 % for females over 15 years of age.

Improved housing conditions have also had a positive effect on the prerequisites for health. This is reflected by the fact that in 1986, about one fourth of all persons over 15 years of age were living in too small houses whereas the corresponding share was less than one fifth in 1994. As concerns the number of rooms, those with too small homes are mostly families with children. In 1994, over 10 % of all persons over 15 years lived in insufficiently equipped houses. Despite improvements, 20 % of the elderly hand an insufficiently equipped home.

The traditional housing level meters do not, however, take the new problems into consideration. They are shown by the increased housing insecurity both in rental and privately owned housing. Heavy housing mortgage payments constitute a problem, especially for families with children. The building and the housing milieu and its suitability for children, the old and the disabled can also be included as factors describing housing conditions. Very little is know about these aspects.

In Finland, the change in industrial and trade structures has been exceptionally rapid and sharp as labour has moved from primary production to industry and services. The share of primary production is, however, noteworthy. About 7 % of labour is employed in agriculture, 21 % in industry and 64 % by the service sector.

The many other changes that have taken place in Finnish society have most probably had an influence on public health, but the causalities and the impact of the changes are not clear. Such factors include the migration from scarcely populated areas towards population centres, the replacement of the traditional, marriage-based two-parent family by new forms of living, and the increasing number of divorces, blended or step-parent families and single-parent families. Society is clearly breaking into a growing number of subcultures, a factor that makes health education more difficult in the years to come.

The rapid change of the living environment also influences mental health. On one hand, the development has provided many persons with possibilities which previously were out of their reach, but on the other hand it has eliminated the psychological support provided by a stable environment. The most rapid social change started to decelerate in the 1980s, and, for example, the number of significant human relations of the Finns started to increase. The economic changes brought about by the economic depression in the early 1990s have also created unprecedented insecurity in the economic and social outlook of the individuals and families.

One of the major factors threatening the health of the population in the near future is the continuing large-scale unemployment and particularly the massive long-term unemployment. The immediate health impact of the economic depression and the unemployment related to it has been surprisingly small. This is at least partly due to the decreases in the consumption of alcohol, smoking, traffic and accidents at work. In a longer perspective, however, unemployment increases marginalization, with its various negative effects on the health of the population.

Utilization of information and information technology have become important productive and competitive factors. Information technology is also becoming the instrument for work, study and leisure for an increasing number of persons. Information networks constitute the most recent form of information technology that will profoundly influence the structure of the companies and society. The networks will revolutionize printing technology, culture and entertainment.

2.5 Economic development in Finland

Towards the end of 1993, Finnish economy started to recover slowly after the long-lasting depression (Table 1). The economic growth accelerated during the years 1994 and 1995 as the rapid growth in exports and increased activities in the domestic market lifted total production to almost pre-depression levels. However, recovery did not touch all sectors. Despite the growth in total production, the effects of the depression on the economy are still visible in the form of high unemployment rates and rapidly growing public debt.

During the depression, the rate of unemployment rose to its maximum, or 18.4 % in 1994. Even if unemployment took a slowly downward turn in 1995, it is a structural and social problem that has become increasingly severe as the number of long-term unemployed, or the persons uninterruptedly unemployed for over a year, has increased. Towards the end of 1994, almost 30 percent of all unemployed were long-term unemployed.

The public debt rate is a consequence of the narrowing income basis caused by the collapse in domestic demand, and of the additional expenses incurred by the government due to unemployment and the support provided for the banking system. As the depres-

Table 1. Economic development in Finland in 1991-1996

	1991	1992	1993	1994	1995 *	1996 **
GNP (change %)	-7.1	-3.6	-1.2	4.4	4.4	3.8
Current account, % of GNP	-5.4	-4.6	-1.3	1.3	3.5	2.7
Consumer prices (change %)	4.1	2.6	2.2	1.1	1.0	1.3
Rate of unemployment (change %)	7.6	13.1	17.9	18.4	17.2	16.0
Public debt, % of GNP	17.1	34.7	53.0	60.4	65.1	68.8

* Advance information **Forecast

Sources: Economic development forecast, Ministry of Finance, February 1996
Bank of Finland Bulletin Vol 69 No 10.

sion prolonged, the chronic deficit of the public economy and the accumulation of the costs generated by the debts have created a debt spiral which, over a short period of time, made the share of public gross debt rise to over 60 percent of gross national product. The Finnish debt rate is not unusually high by international standards. However, it is disquieting that the budget deficit in relation to the volume of the economy is among the largest in all OECD countries. Debt management is made more difficult by the high share of foreign debt, a factor that limits the scope of action of Finnish economic policy.

In municipal economy, the depression has resulted in decreased revenues, at first as concerns municipal tax revenues and later in the form of the income deriving from state subsidies. In 1994 the tax revenue took an upward turn.

As concerns the financing of the welfare services, the central characteristic of the depression and the public finance crisis has been the fall in income taxes and social security payments resulting from decreased wages and salaries, as well as the diminished yield of taxes on commodities as a consequence of the collapse in private consumer demand. In the welfare and health service system, the changes in the economic situation are mostly reflected in the form of cost containment requirements. In addition, changes in the need for certain social services, and possibly for health care services, have been caused by the high rate of unemployment in particular.

2.6 International development and integration

In 1995, Finland became a member of the European Union. In most union member states, the level of public health is higher than in Finland. This is principally explained by their lower rate of mortality in cardiovascular diseases which, however, has rapidly decreased also in Finland. Integration has probably no direct and simple effect on the health of the population. Finland has been able to increase the level of health in certain areas more rapidly than the other Union member states (dental health of children, cancer prevention measures), and the harmonization of the internal market may have an influence on Finland's possibilities to provide successful health protection. The major public health threats caused by the European Union are related to the increased intoxicant criminality as a consequence of less severe control at the borders, as well as to the changes in alcohol policy caused by the Treaty of Accession.

As regards Finland, the development in the neighbouring regions, in Estonia, in other Baltic states and in the St. Petersburg region are of central importance. Infectious diseases which have almost disappeared in Finland occur in these areas. Increased interaction and travelling open new channels for their spreading. The generally low price level in Finland's neighbouring areas is reflected in all products, and also in those with adverse health effects. The importation of cheap alcohol, cigarettes and various kinds of pharmaceutical substances increases the quantities consumed.

3. TRENDS IN PUBLIC HEALTH

3.1 HEALTH BEHAVIOUR AND RISK FACTORS

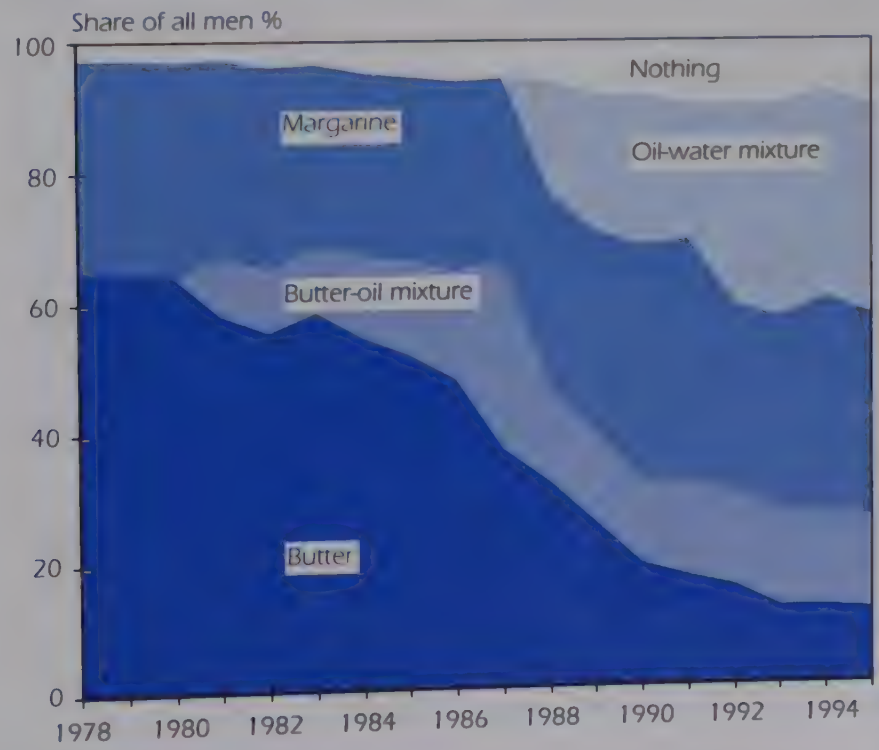
3.1.1 NUTRITION FACTORS

Nutrition plays an important role for the emergence of the coronary disease and cerebral apoplexy, and the changes in nutrition have greatly contributed to the decreased occurrence of these diseases in Finland. Nutrition factors also influence the emergence of hypertension and cancer, and they play a role in the emergence and prognosis of both diabetes and osteoporosis. Through obesity, nutrition also influences the occurrence of many musculoskeletal diseases. Healthy nutrition consist of many vegetables, modest amounts of saturated fats and salt, and it must include a lot of nutritive fibers, vitamins and minerals.

The most important change in the Finnish nutrition has been the decrease in the consumption of saturated fats. In the early 1970s, saturated fats accounted for 23 % of the total energy supply. In 1982 the corresponding figure was 19 %, falling to 16 % in 1992. During this period, the share of all fats has decreased from 38 % to 34 %. According to the recommendations of the State Advisory Board for Nutrition, saturated fats should account for 10 % of the total energy supply from nutrition, the corresponding share of total fat consumption being 30 %. Even if the objectives have not yet been met, the Finnish fat consumption is no longer exceptionally high by international standards. The share is about the same as in Sweden, Norway and the United States and lower than in Denmark, Holland and Germany. The decrease in the consumption of saturated fats is due to many factors, the most important being the diminished consumption of milk fat. This is evident if we look at the decreased consumption of butter (see Fig. 1.).

The consumption of fruit and berries has increased, and the use of vegetables has doubled over the last decade. Finland is no longer an exceptional country with

Figure 1. USE OF FAT ON BREAD IN 1978-1995, MALE OVER 15 AND UNDER 64 YEARS



Source: National Public Health Institute, Adult health behaviour questionnaires 1978-1995.

a low consumption of vegetables and fruit. Even if much attention has been paid to the use of salt, Finnish men still use some 12 gr and women 9 gr of salt every day, the maximum amount recommended by the Advisory Board for Nutrition being 7 to 9 gr. The average supply of vitamins and minerals is good. The supply of fibers does not meet the recommendations (30 to 35 gr daily), even if the figures (25 gr for men and 20 gr for women) correspond to the good Scandinavian level.

Women's diet is in almost all respects more healthy than that of men. This is above all seen in lower fat and salt use and more abundant consumption of vegetables and fruit. The diet differences between various professional groups and regions have diminished, even if the consumption of saturated fat continues to be highest among farmers and non-skilled workers. The eating habits and supply of nutritive substances among the elderly is generally good, even if there may be some deficiencies among certain special groups. It has been assumed that due to the economic depression, people would have less possibilities to buy variable and healthy food, and there have been reports of certain people having actual hunger. There is, however, not yet sufficient research to back or to dismiss these allegations. The first, recently published nutrition report gives a good description of the development of nutrition as well as of the supply of nutritive agents and food among Finns. In the future, there will be annual updates of this report.

The positive development in nutrition during the past few years is mainly a result of the intense recommendation and councelling activities as well as the citizens' own activity. Unfortunately the food-related price and tax policy have not always supported these trends whereas the food industry and the respective legislation have significantly contributed to the positive development.

3.1.2 Obesity

By international standards, obesity has been relatively common in Finland since at least the 1960s. Obesity among the young and your middle-aged men has continuously increased over the past two decades. Young women were still relatively slim in the end of the 1970s and early 1980s whereas even the young women seem to have been gaining weight during the past few years.

Over-weight is most common in the rural areas and less common in the population centres, especially in the Helsinki metropolitan area. It is more common among the less-educated than the well-educated persons. The treatment of obesity has proved to be quite difficult so that more attention should be paid to prevention.

3.1.3 Sexual behaviour

Sexuality is a positive resource. Finns are today more satisfied with their sex life than they used to be. The choice and use of contraceptive methods has contributed to a more liberal attitude towards sexuality. About 80 % of women between 18 and 44 years of age need to use some contraceptive method. The pill is the most common method, especially among the young women. The other common methods include the condom, the IUD and sterilization.

The number of abortions has continued to decrease, most markedly among the youngest age groups. Hormone replacement therapy of menopausal or postmenopausal women has become more common.

3.1.4 Physical exercise

Physical exercise promotes health in multiple ways. Regular exercise diminishes the risk for coronary disease, osteoporosis, obesity and adult diabetes, and lowers the blood pressure. It may also diminish the occurrence of mental health disorders and certain forms of cancer. A moderately straining exercise of about an hour, for example a brisk walk, performed regularly a few times every week, is sufficient as health promoting physical exercise.

One third of all adults do enough exercise to promote their health, and the number of these people has continued to increase during the past few years. Increased physical exercise can be seen in all age groups, in all parts of the country and in all education groups. However, the changes are the most marked among the men who have received most education.

3.1.5 Smoking

Since the 1960, men's smoking has shown an almost uninterrupted decline. The number of smoking women increased until the early 1970s, remaining stable until a new increase started in the middle of the 1980s. Today, 29 % of men and 19 % of women between 15 and 64 years still smoke.

The decrease in men's smoking is seen in all education groups. The well-educated men smoke clearly less than the men with a shorter training. Smoking among the well-educated women has not increased whereas the women with the shortest training smoke clearly more often. By international standards, smoking among adults is less common in Finland than in most countries whereas the frequency is quite high among the young.

3.1.6 Intoxicants (alcohol and drugs)

'Intoxicant use' refers to the use of substances that have an intoxicating effect on the central nervous system.

Among these substances, alcohol is the most commonly used, and it is allowed to supply and consume alcohol in the framework of the respective regulations. In Finland, the law prohibits the use and, in particular, the holding and sale of actual narcotics. In addition, numerous other pharmaceutical substances affecting the central nervous system as well as dissolvents can be used as intoxicants.

In 1994, the average Finnish per capita alcohol consumption rose to 6.6 liters. In addition to this consumption included in the official statistics, it is estimated that there is an additional consumption of 1.5 liters not shown by the statistics. The consumption started to rise towards the end of the 1980s but after reaching the peak in 1990, it has started to decline.

As concerns the consumption of alcohol, Finland represents the average among western industrialized countries. Compared with the other Scandinavian countries, the consumption of alcohol is clearly higher in Denmark whereas it is lower in Sweden and Norway.

The structure of Finnish alcohol consumption is changing, and the Finns have started to favour milder beverages. Today, slightly over 50 % of the alcohol consumed is in the form of beer. The spirits account for about one fourth. Drinking habits have undergone changes over the past few decades. The number of totally abstinent persons is smaller and the frequency of drinking has increased but the volume of alcohol consumption has remained almost unchanged. Even if consumption has to some extent levelled off, the distribution of alcohol consumption is still quite uneven. The heaviest drinking tenth consumes over half of all alcohol. Men continue to drink most of the alcohol but women's share of the total consumption has slowly grown to almost one fourth.

It is difficult to define the frequency of alcohol abuse, extremely dependent on the criteria used. According to the 1992 drinking habit study, 22 % of men and 5 % of women between 15 and 69 years can be classified as risk consumers. This way there would be some 400,000 risk users in Finland. If the limit for heavy use is set at 30 liters of alcohol per year, there are over 200,000 large-scale users in Finland. The immediate adverse effects of alcohol consumption are parallel to the changes in consumption while the long-term effects, such as hepatic cirrhosis, do not show any decrease as a result of slightly diminished consumption.

There is no precise information as to the frequency of the abuse of psychopharmaceuticals. However, it is considered that after alcohol, they constitute the second group of intoxicants used by the Finns, far more frequent than the actual narcotics. The comparison of the results of the studies made in 1991 and 1995 among the patients in intoxicant abuser care suggests that the abuse of psychopharmaceuticals is the most rapidly growing type of abuse.

In Finland, the most frequently used narcotics are cannabis and amphetamine and its derivatives. The number of cocaine and heroin users has remained relatively low. Narcotics abuse is associated not only with dependency and mental health disorders but also with many somatic complications.

Precise figures on the frequency of narcotics abuse are not available but the information from various sources seems to suggest that the volume which had remained relatively constant for about a decade has started to grow during the past few years. According to the 1995 health behaviour study made among the young, almost half of the youngster know someone in their immediate environment who is a narcotics user, one fifth reports having been offered drugs, and some 5 % say they have experimented with drugs. The abuse is most frequent in the Helsinki metropolitan area but is clearly spreading all over the country.

One of the most disquieting features of narcotics and intoxicant abuse is the concomitant use of several substances. The concomitant use of various psychopharmaceuticals with different kinds of effects exposes the abuser to multiple complications not caused by one single substance. The actual frequency of mixed drug abuse is not known to us but certain studies suggest that the concomitant abuse of various intoxicants seems to be increasing.

3.2 Functional capacity, perceived health and mortality

The information about the perceived functional capacity and health can be regarded as the general indicators of public health. This information can be completed with objective data from medical examinations. All these evaluations include a definer-dependent subjective component, and therefore the results cannot be considered absolute but rather indicative of a general situation and trend. The mortality and life expectancy data is quite precise and constant, allowing comparisons over a longer period of time but these figures represent only one, yet the most serious component of public health.

3.2.1 Functional capacity

The perceived functional capacity and the frequency of related deficiencies has been the object of many studies based on questionnaires and interviews. As the questions vary from study to study, it is not possible to give a

uniform description of the results. Naturally, functional capacity decreases with advanced age.

According to the interviews in the 'Mini-Finland' study, about 7 % of the population between 30 and 64 years has some problem limiting their daily functions whereas over one fifth of all over 65s perceived similar problems. Daily functions refer here to such actions as dressing up and undressing, moving about in the home or getting up from bed. The frequency of various functional problems varies greatly in accordance with individual needs and with the individual problem discussed. The most frequent problems are related to limited mobility. So far, there is not very much comparable information about changes in functional capacity. However, on the basis of the interviews made by Statistics Finland it is possible to estimate that the functional capacity of Finns has somewhat improved during the last few years.

Due to the aging population structure, the number of persons perceiving problems in functional capacity is going to increase during the next few years. On the other hand, the results from certain repeated interviews suggest that in the future, the older age groups will have more functional capacities. Basing the estimation merely on the changes in age structure, the need for institutional care of the elderly will clearly increase in the foreseeable future. The better functional capacity of the age group soon reaching old age may level off this need.

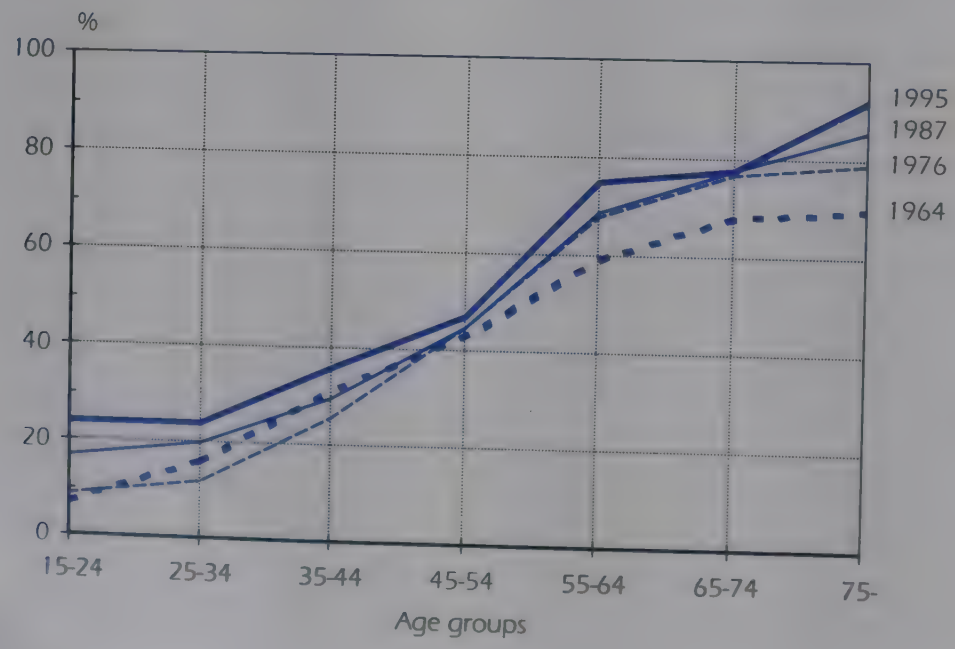
The occurrence of new daily sickness allowance periods and invalidity pensions reflects the functional and working capacities of the population in active working age. The changes in the social insurance benefits and labour market requirements make unambiguous comparison between different periods difficult. However, it seems that the number of short periods of disability expressed in terms of sickness allowance periods has decreased to some extent. Almost 9 % of the population in active working age receives an invalidity pension. Since the mid-1970s, this percentage has remained practically unchanged. The incidence of new invalidity pensions was the highest in mid-1970s, and decreasing during the following decade, and after a slowly increasing tendency in the late 1980s, it has started to decrease during the last few years. The possibility to apply for an individual early invalidity pension has increased the number of persons in early retirement.

3.2.2 Perceived health

On the basis of interviews, over 40 % of adults report that they suffer from some chronic disease. The number of those reporting disease increases with the age: 12 % of the under-15s had a chronic disease while the figure is 90 % for those over 74 years of age. According to the

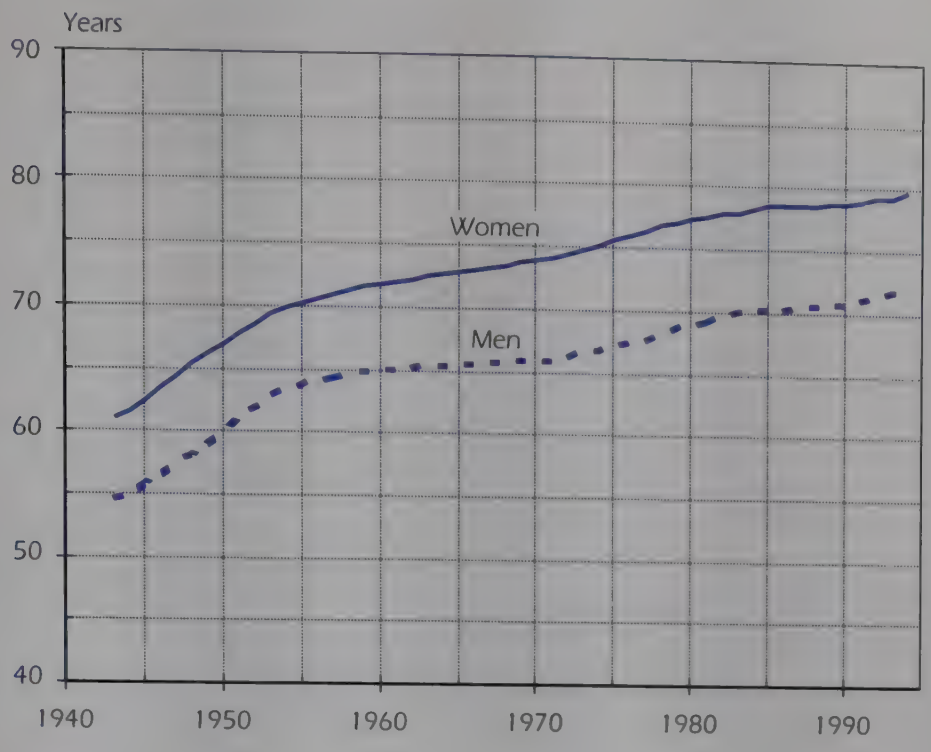
Figure. 2

Share (%) of chronically ill persons of the adult population by age group in 1964, 1976, 1987 and 1995



Sources. Kalimo et al. 1982, Kalimo et al. 1992; Klaukka T. Unpublished advance information about the population survey of 1995 by the Social Insurance Institution.

Figure 3. **INFANT LIFE EXPECTANCY FROM 1941 TO 1994**



Sources: Statistics Finland (Statistical Yearbook of Finland; mortality and survival tables).

interviews, two thirds of all adults consider that they are in good or fairly good health. The percentage of those reporting chronic disease has not shown any relevant change since the 1970s. It seems, however, that during the last few years, less severe diseases have been reported as chronic diseases (Fig. 2.).

The tendency to have chronic diseases is more frequent in the eastern and northern parts of the country. It is more frequent among those who have received less education than among the well-educated population. The regional and educational disparities related to chronic diseases show parallel trends over a period of time even if the proportional differences have to some extent diminished during the last few years.

3.2.3 Mortality

Finnish mortality has been diminishing since the 1940s, and life expectancy has increased (see Fig. 3.)

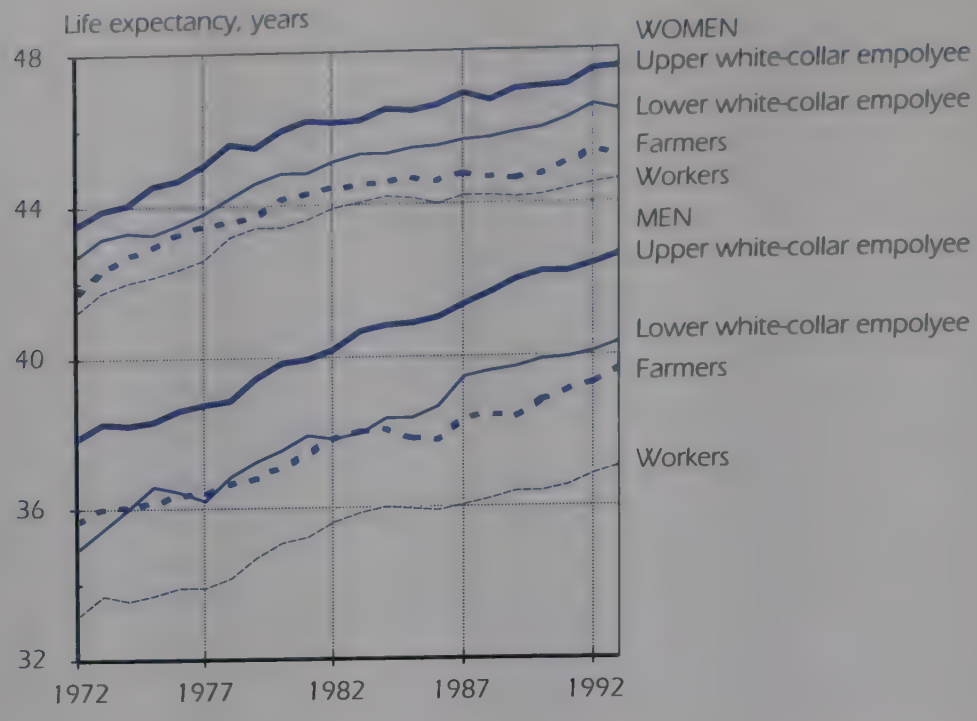
Mortality of Finnish men in the 1950s and 1960s was exceptionally high by international standards, above all due to the high rate of mortality in coronary disease. The difference between Finland and the Scandinavian and other European countries has become smaller since the 1970s. The life expectancy of men (72.8 years) is still two years shorter than in other Scandinavian countries but the life expectancy of women (80.2) is globally among the highest.

Although the mortality rates have diminished, the regional disparities have not disappeared. The coastal areas and southwestern and western parts of Finland are characterized by low mortality whereas mortality is high in eastern and northern Finland. The disparities are more marked in the mortality of men, principally explained by cardiac diseases, cancer and accidents. Mortality is clearly most frequent among the less educated and least frequent among the most educated population groups. During the last few years, decrease in mortality has been relatively uniform in all social groups, yet somewhat more rapid among the persons who have received the longest education so that the disparities in mortality between population groups have not levelled out but rather become somewhat more marked (Fig. 4).

3.3 Frequency and trends in widespread common diseases

The terms widespread and common refer to the diseases, the frequency and consequences of which cause most harm among the population. In the recent years, the major widespread diseases in Finland included circulatory diseases, cancer, musculoskeletal diseases and mental health disorders. Besides these traditionally widespread diseases, today's common diseases also include allergies, chronic lung diseases and diabetes. Infectious

Figure 4. **LIFE EXPECTANCY OF THE 35-YEAR-OLDS BY SOCIAL GROUP AND SEX IN 1971-1993.**



Source: Martikainen and Valkonen, 1995.

diseases continue to play an important role, even if they are not considered as widespread common diseases. Accidents have marked public health impact although they are not included in the category of widespread diseases.

3.3.1 Diseases of the circulatory system

The major Finnish diseases of the circulatory system include the coronary disease, cardiac insufficiency and cerebral apoplexy. Most of them are developed as a consequence of arteriosclerosis.

Increased blood pressure and hypertension are quite frequent among Finns. One fifth of all over-30s have so high blood pressure that medication or other forms of therapy are indicated. Towards the end of 1994, 11 % of the population, or 440,000 persons, were entitled to special sickness reimbursement for this reason. High blood pressure is most frequent in eastern and northern Finland even if the disparities between the various regions have become smaller over the past few years. In the middle-aged population, increased blood pressure is more common among the lower social groups. The overall level of blood pressure in the population has shown an indisputable decrease as of the 1970s. This is mostly due to more efficient medication but the changes in lifestyle also play a certain role. Despite the marked increase in the efficiency of blood pressure therapy, it is estimated that half of the persons medicated for hypertension have not had a sufficient decrease in their blood pressure.

The increased blood cholesterol content is one of the main reasons causing circulatory diseases. Since the 1960s, the cholesterol concentrations of the Finns have shown a decrease, mainly owing to improved eating habits but the concentrations remain high by international standards. About one fourth of all adults have so high total cholesterol concentrations (over 6.5 mmol/l) as to necessitate active treatment. Raised cholesterol levels are more common in eastern and northern Finland, as well as among the lower social groups and farmers.

Coronary disease became more common among the Finns, especially men, in the 1950s and 1960s (Fig. 5.). In the late 1960s, middle-aged Finnish men ranked highest in the international statistics for mortality in coronary diseases, and the women did not come very far behind. Since the early 1970s, mortality in coronary disease as well as the occurrence of the disease have taken a clearly downward turn. Mortality has decreased by 60 % in two decades. Despite the decreased occurrence and mortality, coronary disease remains quite common. About 14,000 persons die of coronary disease every year, and over 150,000 persons are entitled to the special reimbursement for the related medication. Eastern and northern Finland are most affected by coronary disease, and in the middle-aged

population, it is more common among the lower social groups. Diminished smoking, improved blood pressure treatment and lower blood cholesterol concentrations are undeniably important factors contributing to the decrease in mortality in coronary disease but the highly developed forms of therapy have certainly also had an important role. In the future when the disease among the middle-aged population will have become less frequent, the health care resources will be burdened by the persons who get coronary disease in old age. The load will be further increased by the aging population structure.

In Finland, cardiac insufficiency is principally caused by coronary disease or hypertension. In the end of 1994, 125,000 persons were entitled to the special reimbursements for their cardiac insufficiency medication. The occurrence of cardiac insufficiency has clearly diminished during the past few years. This is partly due to the prevention of conditions causing cardiac insufficiency, to improved therapy and partly to more accurate diagnostic practice.

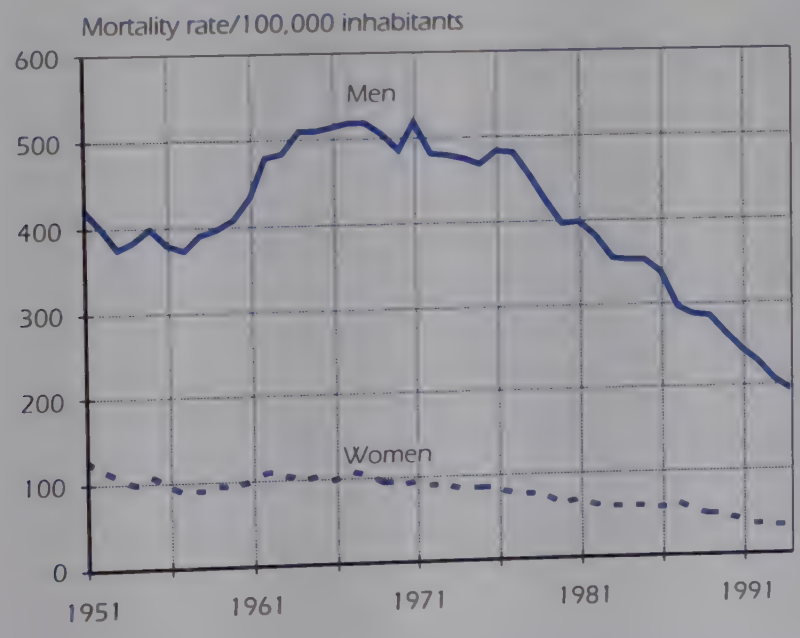
Mortality in cerebral apoplexy has shown continuous decrease in Finland. Although the downward trend started before the introduction of modern blood pressure drugs, the more efficient treatment of blood pressure has greatly accelerated the decrease during the past few years. Mortality in strokes has decreased but the number of days the apoplexy patients are treated in hospitals has shown a marked increase. This is mostly explained by the aging population structure. The occurrence of apoplexy increases rapidly with age. The recovery of an elderly patient from a stroke takes longer, prolonging the duration of the treatment.

3.3.2 Cancer

After cardio- and cerebrovascular diseases, cancer is the most frequent cause of death in Finland. Every year, about 19,000 persons get cancer and some 10,000 die. The morbidity of men has remained practically unchanged since the 1950s. Although there are no changes in overall morbidity, there are significant differences in the occurrence of individual cancer forms. Male lung and gastric cancers have shown a rapid decrease while prostate cancer morbidity has grown significantly. Cancer among women has shown a small consistent growth. As is the case with men, the occurrence of individual cancer forms in women presents great changes over a period of time. Women's gastric and cervical cancers have diminished radically but the occurrence of breast and uterine cancers has constantly grown. The frequency of lung cancer among women has also clearly increased, even if it is far less frequent than among men. Both sexes have an increased incidence of cancer of the large intestine and melanoma.

Some of the time-related changes find an explanation but most of them remain unexplained. Undeniably, the altered smoking habits explain the changes in the occurrence of lung cancer while changes in eating habits are thought to play a role in the more frequent occurrence of cancer of the large intestine. The increased

Figure 5. **Age-standardized mortality in coronary disease in 1951-1994, population between 35 and 64 years of age**



Source: Statistics Finland, Causes of death statistics.

exposure to UV radiation due to growing tourism may be a factor causing the increased occurrence of melanoma. Mass controls have significantly contributed to the diminished frequency of cervical cancer. The factors causing the growing frequency of the two major cancer forms from the public health point of view, breast and prostate cancer, have not yet been sufficiently clarified.

Cancer morbidity shows some social group and regional disparity but it also shows variation by cancer type and sex. As a rule, the cancer types related to a lower social group, such as gastric cancer in both sexes, men's lung cancer and female cervical cancer, have diminished whereas the forms more frequent among the upper social groups, such as the cancer of the large intestine in both sexes, prostate cancer in men and breast cancer in women, have shown a growing tendency in Finland.

The prognosis of cancer patients has constantly improved. This is mostly due to improved therapy but also to the fact that the disease is today diagnosed earlier. In the future, the aging population structure will increase the number of cancer patients and the need of resources required for the treatment.

3.3.3 Mental health disorders and dementia

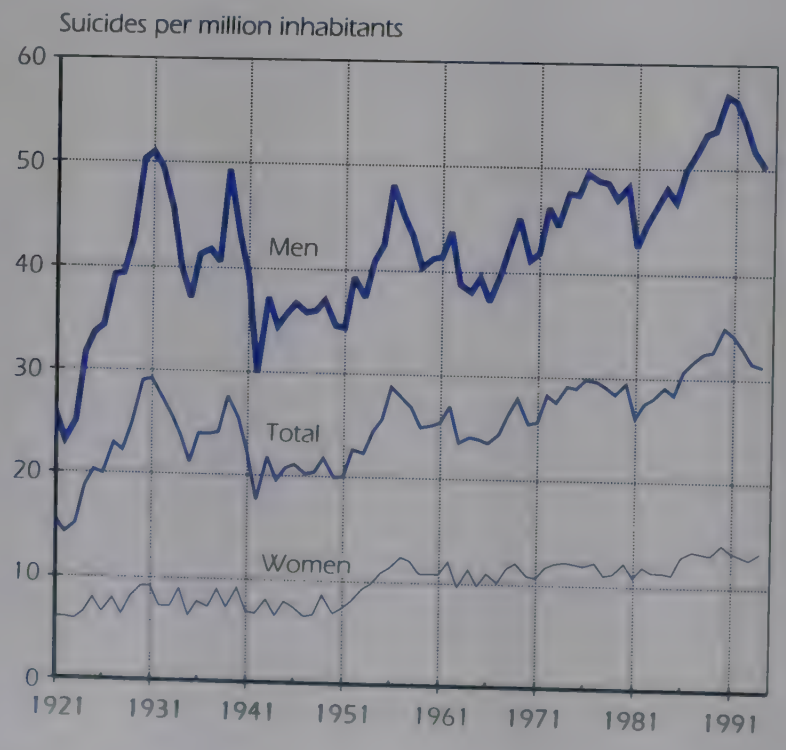
Over half of the population has perceived symptoms related to mental health. In their own opinion, one in ten among the adult population report that they suffer from mental health disorders. Evaluated clinically, the disorders are more frequent than that. Depending on the assessment criteria, the occurrence varies but approximately 20 % of the adults have mental health problems. The occurrence of psychotic disorders is 2 % and neuroses about 13 %. The disorders become more frequent towards the early retirement age and grow less frequent among the elderly.

Disability related to mental health disorders has become more frequent since the early 1970s, and today they constitute the most frequent group of diseases causing disability. The growth of neurotic disorders has been most marked. There is not enough comparable data to evaluate with certainty whether the increased share of disability due to mental health disorders is a consequence of an actually higher frequency of these disorder or whether now the causes also include less severe disorders.

In Finland, suicides constitute a significant cause of premature death, and this is especially the case with young men. The relative and absolute frequency of suicides continued to grow from the 1940 until the year 1990 but since then there has been a slight decline (Fig. 6).

In international suicide frequency comparisons, Finland is among the first few countries. The rate of pre-

Figure 6. **Suicide mortality in 1921-1994**



Source: Statistics Finland, Causes of death statistics

mature deaths caused by suicide among Finnish men under 35 years of age is exceptionally high by international standards. The large-scale nation-wide suicide prevention campaign implemented during the past few years will be helpful when new ways of prevention are looked for in the future.

Dementia is a progressive functional brain disorder, not classified as an the actual mental health disorder. However, its consequences make the patient permanently dependent of care and attendance as his or her memory functions progressively fail. Dementia can be caused either by an independent brain disease, Alzheimer's disease, or it can be a consequence of disturbance in brain blood circulation, the so-called vascular dementia. The occurrence of dementia radically increases after the retirement age. According to the latest studies, four percent of the population between 65 and 74 years of age and one third of all over-85s have dementia. So far, we know too little about the factors causing dementia to be able to plan any efficient preventive measures. The aging population structure will greatly increase the number of those having dementia. In 1995, there were approximately 70,000 persons suffering from dementia while their number will exceed 90,000 in 2010.

3.3.4 Musculoskeletal diseases

Musculoskeletal diseases are the most frequent pain-causing diseases among the population, and they also cause most absences from work. More than a million Finns are estimated to suffer from some musculoskeletal disease, and over half a million have some continuous functional problems related to it. The most frequently occurring musculoskeletal diseases include degenerative arthritis, lumpago and sciatica, shoulder-neck pain and syndromes as well as rheumatoid arthritis. According to interviews and invalidity pension statistics, musculoskeletal diseases have become clearly more frequent during the past few decades. This is particularly the case as concerns lumpago, shoulder-neck syndromes and degenerative arthritis. The musculoskeletal diseases were an increasingly frequent cause for invalidity pensions until the late 1980s and after that the number has started to decline. According to the latest health interview of 1995, the growth of the share of musculoskeletal diseases of all long-term ailments has remained static among men and started to decrease among women.

Artrosis affects the articular cartilage, and the occurrence is strongly age-dependent. About ten percent of Finnish adults has artrosis of the knee, while the hip joint of five percent of the population is affected by this disease. Artrosis is more frequent among those with less education and among the agriculture and forestry professions. As a consequence of the aging population structure, the problems of decreased functional capacities caused by artrosis will become more frequent whereby the health care systems is increasingly burdened, especially as concerns orthopaedic procedures.

Lumpago is fairly frequent. Over fifty percent of all adult Finns have had lumpago more than five times, and one fifth has had lumpago during the past month. Lumpago was an increasingly frequent cause for invalidity pensions until the late 1980s but after that the trend has taken a downward turn. Shoulder-neck pains are likewise quite frequent, even if backaches tend to be more frequent among the long-term syndromes. Shoulder-neck problems are also less frequent causes for permanent decreased working capacity than the backaches.

Compared with other musculoskeletal diseases, rheumatoid arthritis is fairly rare. Slightly over two percent of the Finns suffer from rheumatoid arthritis. Even if the occurrence of this disease is relatively low, it causes a significant load on the health care system. Rheumatoid arthritis patients account for 40 % of hospital treatment days among the musculoskeletal disease group.

3.3.5 Allergies

Allergies and asthma are among the fastest increasing widespread diseases. About 5 % of the population suffer from asthma, and about 10 % have periodic asthmatic symptoms. In the end of 1994, 140,000 persons were entitled to special reimbursements due to asthma medication. Almost one fifth of the population suffers from atopic skin problems at some point of their lives. Ten percent suffer from allergy-related rash in the hands or from irritated skin in the sensitive contact areas. One in five Finns has allergic rhinitis.

Both asthma and probably also other allergic diseases have become clearly more frequent during the past three decades. This is partly due to more accurate diagnostics, but it is quite certain that the actual occurrence of the diseases has also increased, the causes, however, remaining unclear. Some of the causes are surely connected to the urbanization and industrialization whereby the population is exposed to the environmental polluting agents and to an increased number of chemical compounds. Both active and passive smoking probably also play a role. Nutrition, decreased childhood infections and improved housing hygiene factors have also been considered but their importance remains unclear.

During the past few years in particular, decisive improvement has been achieved in the treatment of asthma. In Finland, mortality caused by asthma is extremely

low by international standards. Owing probably to the intensified long-term treatment, the need for asthma-related hospitalization has continuously decreased.

3.3.6 Chronic obstructive lung disease

With the exception of certain hereditary enzyme deficiencies and rarely occurring dust exposures, chronic obstructive lung disease, manifested in the form of chronic bronchitis, emphysema or progressive constriction of the respiratory tract, is almost always a result of long-lasting smoking. Almost a fifth of all smokers get obstructive lung disease. The occurrence increases by age, and varies between 3 and 21 % among the men over 30 years of age, the corresponding occurrence rate among women being between 2 and 11 %. The disease starts with quite insignificant symptoms and the progress is slow. The permanent irreversible changes in the lungs start to cause problems only in old age.

Once the chronic obstructive lung disease has progressed to lung insufficiency, it requires a lot of health care resources, and is often a cause contributing to death. The changing age structure of the Finnish population, and their long smoking tradition will increase the need of treatment caused by this disease. Smoking among men has shown a very positively decreasing trend but it is only after a number of years that this will be reflected favourably in the disease.

3.3.7 Diabetes

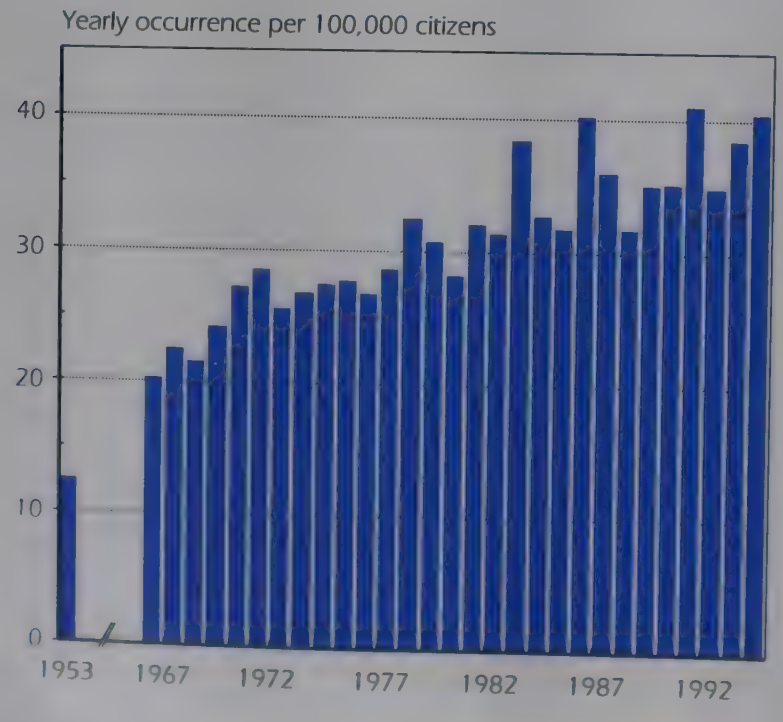
It is estimated that 150,000 Finns have diabetes, and over 110,00 persons are entitled to special insurance retributions due to their diabetes medication. Over 20,000 diabetics suffer from insulin deficiency. The occurrence of insulin deficiency diabetes manifested in childhood has clearly increased in Finland during the past four decades (Fig. 7.).

Finland has the world's highest occurrence of insulin deficiency diabetes. Adult diabetes has likewise become more frequent during the past few decades, yet not as dramatically as insulin deficiency diabetes. The frequency Finnish adult diabetes is not among the highest in the world but is similar to the rest of Europe.

The reasons for the emergence of insulin deficiency diabetes are not yet known. The predisposition depends on genetic factors which are already fairly well known whereas our knowledge is still insufficient as concerns the external factors, related to nutrition or infections and estimated to play an important role. Besides genetic factors, obesity and insufficient physical exercise are among the causes of the disease.

The occurrence of both diabetes types is increasing as the population is aging, and therefore diabetes is going to be a common disease requiring a growing share of health care resources.

Figure 7. **Age-standardized occurrence of insulin deficiency diabetes in children under 15 in Finland in 1953 and in 1966-1994**



Source: Tuomilehto et al. 1995

3.3.8 Infectious diseases

The major infectious diseases causing premature death and permanent handicap were eradicated by the turn of the 1950s and 1960s. However, infectious diseases continue to cause a lot of acute morbidity. Among the elderly, they are also an important factor contributing to death.

New infectious diseases are discovered, and old diseases risk to break out anew due to the changing contacts with Finland's neighbouring areas. Resistance to antibiotics is a new risk threatening the health care related to these diseases. This phenomenon will expand if safe rules are not followed in the utilization of antibiotics.

Respiratory infections are the major short-term causes of morbidity among both children and adults. Even if an individual infection does not last long, their frequent occurrence causes a considerable number of absences and a certain burden to the health care system.

Tuberculosis used to be one of Finland's major widespread common diseases half a decade ago. Since the early 1960s, the occurrence of new cases of tuberculosis has dropped radically. It has been estimated that the present level of morbidity will no longer decrease. This is partly caused by the increasing number of infectious contracted outside Finland. The disease has not been eradicated, a new therapy problems are caused by the TB infections of the immunity deficiency patients and by the cases that are resistant to various forms of medication.

Intestinal infections have become more rare but they still present a challenge for the prevention of infections by both the individuals and the health care system. The range of sexually transmitted diseases has undergone a change over the past few years. Syphilis and gonorrhoea have become significantly less frequent and have been replaced by chlamydia and herpes infections. The overall number of sexually transmitted diseases shows a decreasing trend, although the contacts with the eastern neighbouring countries have lately had an adverse effect on this trend.

Compared with other European countries, Finland has had an exceptionally good HIV infection situation. On an average, less than 100 new HIV infections are diagnosed every year. Finland's remote geographical 'ocation, successful education and the small number of the persons in the risk groups exposed to the infection are probably the factors contributing to unexpectedly low numbers.

The most difficult problems related to the therapy of infectious diseases is caused by the resistance to antibiotics which has recently become more frequent. The Finnish situation is not yet as bad as in certain other European countries but the situation calls for vigilance. The most important measures in preventing the resistance problem is the correct control in the use of antibiotics.

Finnish immunization programmes have been quite extensive, and therefore various serious communicable diseases which used to be quite frequent, such as diphtheria, tetanus, poliomyelitis, serious hemophilic infections, measles, rubella and mumps have been practically eradicated. The immunization programme is being constantly developed, and new challenges have been met with success.

3.3.9 Dental diseases

The most frequent dental diseases include caries and the diseases of the gingival tissues, largely regarded as life-style-dependent diseases, and therefore the individual adoption of health habits plays an important role in their prevention.

Recently, the occurrence of caries has diminished. This is most clearly reflected in children's dental health. For example, today's 12-year-old Finnish child has approximately 1.2 teeth with cavities or fillings whereas the corresponding figure 20 years ago was 6.9. The same favourable development is seen in the share of those with completely healthy teeth (fig. 8.).

Along with the diminishing occurrence of caries, the number of those with no teeth has significantly decreased.

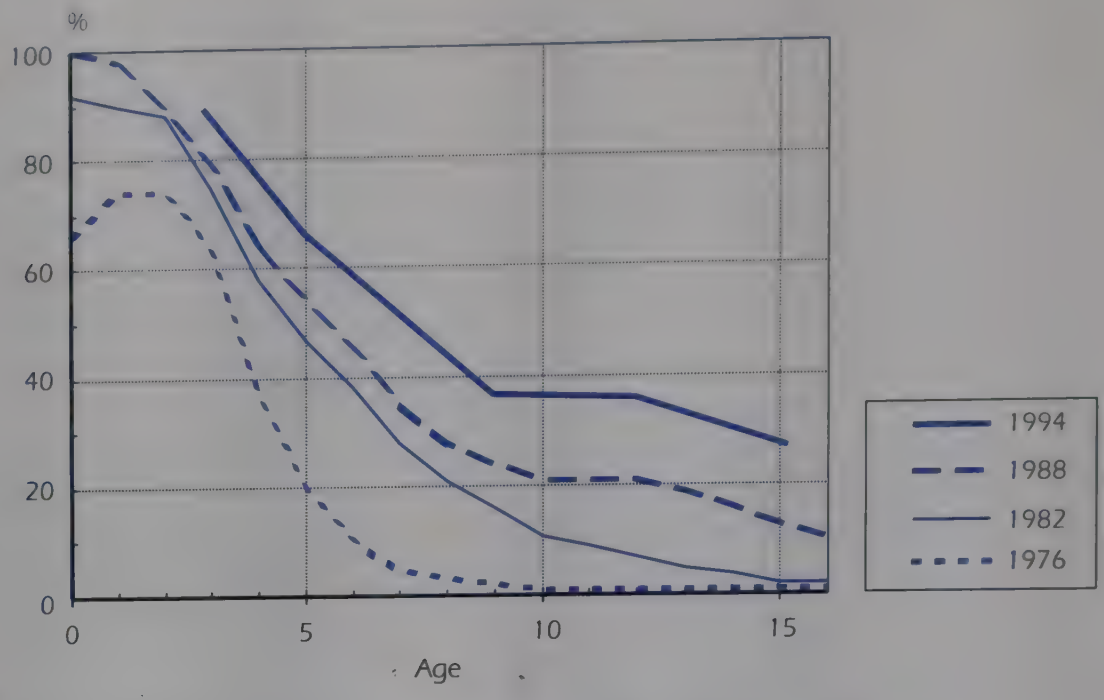
The disparities in dental health between social and education groups remain quite large. Both caries, diseases of the gingival tissue and the total loss of teeth are more frequent among the low-income groups and those with less education, also less frequent users of dental care services.

3.3.10 Occupational diseases

About 7,000 cases of occupational diseases are registered in Finland every year, corresponding to some 300 cases per 100,000 persons in the work force. The occurrence figures correspond to the frequency of the most common diseases. A small number (about 1 %) of the registered diseases are serious and potentially fatal, 20 % cause some type of a permanent handicap, and the rest are less serious and can be controlled through changes made in the work itself.

As concerns the occupational health risks, there are large disparities among the work force; the risk in certain professions can be even 40-fold. The fields most exposed to risks include food industry, industrial work in general, wood-working, construction and metal foun-

Figure 8 SHARE OF COMPLETELY CARIES-FREE CHILDREN BY AGE AMONG THOSE CHECKED IN HEALTH CARE CENTRES IN 1976, 1982, 1988 AND 1994.



Source: Nordblad et al. 1993; Nordblad A. Unpublished advance information of the 1994 study by the National Research and Development Centre for Welfare and Health.

dry and machine shop work. The occurrence of occupational diseases continued to grow gradually all through the 1980s, but the trend took a slowly downward turn in 1990. The prevention of occupational diseases calls for comprehensive work hygiene and ergonomy measures, and Finland has good traditions in these areas.

3.3.11 Accidents

Accidents are classified according to their circumstances into accidents at home and during leisure, traffic accidents and accidents at work. The first group is most frequent, followed by accidents at work while traffic accidents constitute the smallest group. Most of the serious fatal accidents take place at home, 2,000 accidents a year. There are 500 fatal traffic accidents and 160 such accidents at work every year.

Accidents at home and during leisure constitute a large and versatile group, and their relative share of all accidents has recently become more important. The most numerous group of such accidents involves some type of fall. The elderly are most exposed to such accidents, and their importance in terms of public health will be larger as the population is aging. For example, 1,400 old persons were hospitalized in 1968 for a hip fracture, a typical consequence of an elderly person's fall. In 1993 the corresponding figure was 6,300 while the number of hip fracture patients is estimated to rise to 18,000 by 2030 if the present trend continues.

The number of accidents during physical exercise has clearly grown during the past few years. Although the traumata are generally fairly small and cause only short-term invalidity, they are of great importance from the public health point of view. Most physical exercise-related accidents take place during jogging and various ball games whereas alpine skiing causes most injury days in relative terms.

A very positive trend has been seen in fatal traffic accidents. They reached their peak, or 1,100 annual deaths, in the early 1970s. According to the last statistics of 1994 the number has gone down to 480 per year. A similar trend can be seen in the number of persons permanently disabled. The number of vehicles and traffic volumes have changed over the years, and this is reflected in the accident statistics. The increased number of cars partly explains why the share of those who died in a car has decreased relatively less than the share of other persons involved in traffic accidents.

The nature of work, the rate of technology and changes in production technology are strongly reflected in the occupational accident risks. As production was mechanized, the number of accidents at work and those leading to death rapidly increased from the 1960s to the 1970s, whereas their number started to diminish in

the 1980s, showing a new, slightly growing tendency in the 1990s. By international standards, the occurrence of accidents at work in Finland corresponds to the average European level but the situation is far worse than in Sweden.

In relative terms, the decrease in serious accidents at work has been the largest while the trend has not been so favourable as concerns minor accidents. Most accidents at work are caused by traffic at work, by objects falling or dropping or the workers themselves falling, by moving machine parts. Strain injuries are caused when objects are being lifted or transferred.

3.4 Health in various age groups

3.4.1 Children

Finnish children are generally considered to enjoy exemplary good health. This is also the case when most health indicators are being looked at in general but certain health problems tend to show an adverse trend. As in other industrialized countries, Finnish infant mortality is very low. Mortality among the newly-born, the so-called perinatal mortality, and infant mortality have continued to decrease.

The major causes of perinatal mortality include premature births and congenital malformations. More than half of infant mortality takes place during the first week of life, and three thirds during the first four weeks. There are no major regional disparities in infant mortality but there is some variation according to the level of education of the mother. Infant mortality is largest in the group of the least educated mothers.

The occurrence of children's long-term diseases, as declared by the parents in interviews, has recently slightly increased. Depending on the age group, the occurrence of long-term diseases varies between 8 and 16 %. During the past few decades, the range of long-term diseases has changed. Thirty years ago, sensory handicaps and malformations constituted the largest group of long-term diseases while today the most common diseases include asthma, allergic skin problems and various functional and psychological disorders. About ten percent of children and 20 percent of the young suffer from allergic symptoms. The changed in the occurrence of psychological disorders are not accurately documented, but the range of the disorders has undergone a change and in an increasing number of cases, the problems tend to lead to crisis situations. In Finland, the occurrence of insulin deficiency diabetes among children and the young is the highest in the world, and the disease seems to show an increasing trend.

The positive aspects in children's and young persons' health development include the clear decrease in the common communicable diseases, the significant decline in caries and the smaller number of serious accidents.

3.4.2 The young

The term "young" here refers to those over 10 and under 20 years of age. This has traditionally been regarded as quite a healthy age group but the rapid development may involve problems and many health habits with later health impact are adopted during these years.

Although the young are passing a period of their life with the lowest possible risk of contracting chronic diseases, this is the period when they adopt the habits that either promote their health or are adverse to it.

During the course of a person's life, mortality is at the lowest from 10 to 14 years but already during the following five years, mortality increases. Mortality of Finnish young persons caused by diseases has continuously diminished whereas deaths caused by accidents among young boys and men have slightly increased.

About 10 % of the young report to suffer from some long-term disease, asthma and allergies being the most frequent among such diseases. Generally, the young report quite good health but various functional and psycho-somatic symptoms are relatively common. There have been no major changes in the occurrence of these symptoms during the past ten years.

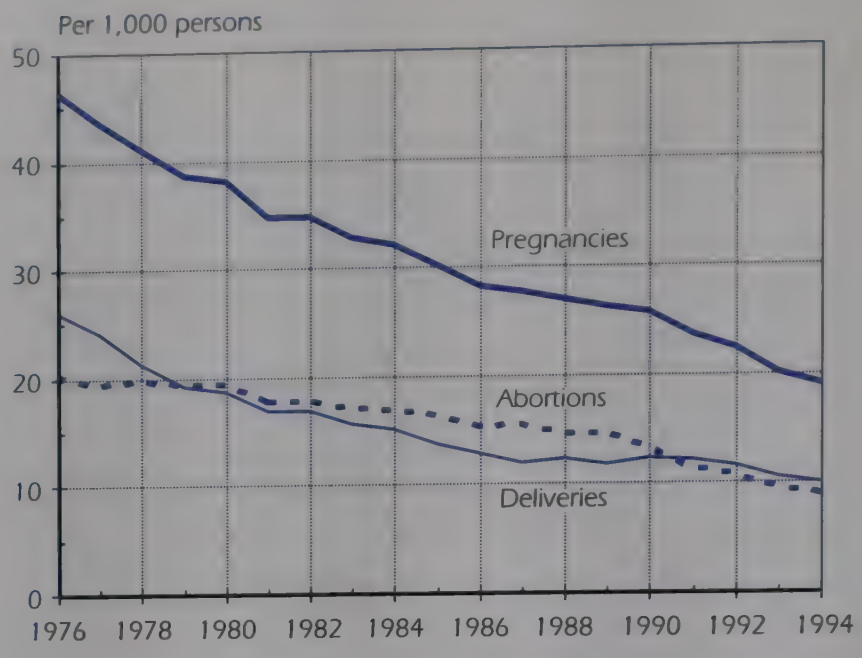
After a declining trend in the 1970s, smoking among the young started to grow in the 1980s. Finnish young persons are among the most frequent smokers in the world. Alcohol starts to be used during this period of age. Although the total consumption of alcohol has in the past few years been declining in Finland, its consumption among the young seems to be growing. A particularly disquieting fact is that the young's consumption of alcohol is increasingly drunkenness-oriented and that such behaviour is starting earlier in age. Both smoking and the consumption of alcohol are more frequent among the young with shorter school background.

A considerable change has taken place in the sexual behaviour of the young. Sexual intercourse starts at an earlier age and is more frequent than in the past. However, the number of pregnancies, deliveries and abortions among the girls between 15 and 19 years of age has radically dropped (Fig. 9.). The favourable trend is due to the more frequent use of contraceptives, especially the pill.

3.4.3 Expectant mothers

Traditionally, Finnish maternity care is of excellent level by international standards. Almost all pregnant women

Figure 9. **PREGNANCIES, ABORTIONS AND DELIVERIES AMONG GIRLS BETWEEN 15 AND 19 YEARS OF AGE IN 1976-1994.**



Source: National Research and Development Centre for Welfare and Health and Statistics Finland.

attend the maternity clinics for examinations, and practically all deliveries take place in hospital maternity wards with good obstetric facilities.

During the past few years, the average age of the expectant mothers has significantly increased while the share of the oldest group of mothers, those over 40 years, has remained almost unchanged. In Finland, childbirth mortality is extremely low. Each year, less than ten mothers die in delivery. About 14 % of Finnish deliveries involve the cesarean section, a number that has remained constant during the past decade.

The number of abortions has continued to decline from the peak in the 1970s. In 1973, over 23,000 abortions were made while the corresponding number in 1994 was 10,000. Most of the abortions are made on social grounds.

3.4.4 The working population

For more than forty years now, occupational health care has been actively promoted. Statutory occupational health care aims at anticipating and preventing the work-related health risks and load factors. This is the principal task of occupational health care, but also the other health problems of the employees are taken care of within the limits of the individual resources

The physical, chemical and biological risks in the work environment are generally well identified and contained. The injuries and inconveniences caused by physical loading have increased even if the work itself is mostly less burdensome physically. This is due not only to the more demanding requirements related to work rhythm but also to some extent to new research and reimbursement practices and the aging of the work force. It seems that work is becoming psychologically harder, mostly due to busy timetables and increased work pressure.

Estimated on the basis of short-term absences, the Finnish work force is more healthy than their Scandinavian colleagues while the occurrence of long-term diseases and invalidity indicate that the Finns are the sickest people among the Nordics. The risk of invalidity varies greatly between different professional groups. The high-risk professions are characterized by significant work load, dangerous or non hygienic work conditions and frequently alternating work environment.

3.4.5 The aged

The probability of various degenerative conditions increases with age. On the other hand, mortality among the aged Finns has decreased and life expectancy has increased. The change in age structure as such will result in considerably larger numbers of people in old age. All these changes indicate that the number of the elderly needing outside assistance will be increasing.

Old persons relate their present situation and life very individually to the past years and, adapting to outside requirements, they tend to consider their health to be

much better than what would be evaluated by an outside observer. For example, half of the elderly living at home consider themselves to be at least fairly healthy although most of them have some diagnosed diseases. One third of retired men and half of retired women suffer from musculoskeletal diseases, one third has angina pectoris, one fifth has had an infarct, one fifth of all men have emphysema of the lung, and a fourth of the oldest age group suffers from urinary incontinence. However, most of the over-75-year-olds and half of the 80-year-olds manage alone in their homes without assistance.

It is difficult to estimate the future health of the aged and how much help they are going to need. Although the number of the aged and, at the same time, the number of those who will have diseases that effect their functional capacities, is going to grow, there are some indirect factors indicating that the occurrence of certain invalidating diseases, especially circulatory diseases, may decline. Therefore it can be anticipated that the number of the aged will be much larger but their functional capacities will be better than they used to be in the earlier generations.

3.5 Relation between public health and national economy

The following factors can be used when assessing the relation between public health and national economy. Firstly, the share of health care expenses of the national product can be assessed against public health. Secondly, the public health/national economy relation can be assessed directly by using such indicators as the changes in life expectancy in relation to the changes in national production. A third method is to assess the effect of different income brackets on the disparities in health by different population groups and on the public health in general. However, the measuring of the relationship on the population level between health and economic well-being involves many problems. Therefore, the existing research seems to give contradictory results.

Comparative studies made in OECD countries indicate a clear relationship between health care expenses and gross national product: the higher the gross national product per capita, the higher the health care expenses. However, when looked at a specific point of time, the share of the health care expenses of the national product does not seem to influence the life expectancy figures. Besides health care, many other factors, such as social welfare services, material standard of living, work and living environment and social environment influence health and life expectancy. Due to the scarce economic resources, the size of the health care sector limits the availability of resources in other sectors. The resources are allocated in an inefficient manner if new resources are given to health care while other sectors could provide more health promoting goods and services.

It is generally known that the material standard of living promotes health. However, contrary to what has been assumed in some studies, there is no direct relationship between health and income bracket. After a certain income level has been reached, increased income does no longer increase health.

International comparative studies which have looked into the relationship between life expectancy and per capita gross national product have shown that the level of gross national product has no public health relevance in developed market economies. Cyclical changes in the growth of gross national product are neither reflected in the health of the population. However, Finland's deep economic depression in the early 1990s was exceptional in the sense that the growth of the gross national product did not only decelerate but the real value of the national product decreased in three consecutive years. No studies have been made on the public health impacts of such changes. Since the general standard of living of the population has remained relatively high despite the economic depression and the social income transfer mechanisms have so far compensated the losses in earnings, it is improbable that any major changes in public health would have taken place due to these factors.

It seems that in developed countries public health can rather be influenced through the levelling of income disparities than through increased gross national product. Since the income does not have a similar health impact in the higher income brackets as it does in the lower, the reallocation of income from the rich to the poor tends to diminish the health disparities between the different population groups, this way contributing to improved overall health. Income differences influence the health of different population groups through a variety of mechanisms.

Firstly, income differences may influence health directly through the health care system. If the persons with the least favourable economic situation need to compromise the quantity and quality of the health care services, the disparities in health may even increase in relation to the upper income classes. The public health care system aims at securing equal access to health care services regardless of the income level or other factors which do not depend on the need of services. The use of health care services does not, however, have any major effect the overall mortality of the population.

Income differences can also effect the allocation of health indirectly through the health care system if the share of income used for health care in the lower income brackets is so large that compromises must be made in other consumption with health impacts. Even if society would in such a case provide, in addition to the actual health services, other services with significant health policy impact, the benefit derived from them from the public health point of view is inefficiently allocated between the various income groups.

In developed countries, a health-related factor that is more important than material well-being or sufficient income is the perceived relative disadvantage. In lower income brackets, the awareness of the fact that one's own economic situation is worse than that of the others may, through various psychosocial factors, have an adverse effect on health behaviour and prerequisites. Other health-related factors of relative living conditions, such as a person's social status, education and position in the labour market, may contribute to this.

It was previously thought that unemployment has only adverse health impact. Certain recent studies suggest that unemployment may - at least in the medium-term - have versatile effects. According to this model, growing unemployment first tends to increase mortality, followed by a decline in mortality over a number of years, to a level that may be lower than prior to the unemployment period. Later, mortality returns to the long-term level which is independent of the unemployment rate. The observations based on epidemiological studies on the relationship of unemployment and health support this time-dependent development of mortality. The most obvious effects of unemployment are seen in mental well-being and health.

The risk of unemployment alone causes psychological stress, and when a person becomes unemployed, this fact is rapidly reflected in his mental well-being. Prolonged unemployed does not cause continuously deteriorating mental health but most unemployed persons seem to try to adapt themselves. Reduced economic operations lead to positive health impacts through fewer accidents at work and decreased need of transportation and commuting. Unemployment may signify a relief from stressing physical or psychological work. During economic depressions, the consumption of alcohol and smoking tend to diminish. The attitude to unemployment is culture-dependent, and the respective effects may be very different in various age groups. In Finland, all population groups have fairly uniformly been affected by the unemployment of the 1990s, which has also made it easier to support the consequences of unemployment.

Prolonged or repeated unemployment is concentrated, and it is hard for the persons involved to change their condition. On an average, the unemployed use more health care services than those at work but it is not clear what the connection between the increased use and unemployment is. It remains unanswered whether the differences are related to unemployment or to health problems existing prior to unemployment. Persons with a long-term disease or the older age groups risk unemployment more often than the average.

4. Principal Lines of Implemented Health Policy

4.1 International background of health policy

4.1.1 World Health Organization

Finnish health policy has developed hand in hand with the World Health Organization policy. The 1978 Alma-Ata Declaration on primary health care has been materialized in the Finnish Public Health Act. The Health for All by the Year 2000 programme, approved by the WHO and by the WHO Regional Office for Europe, and particularly its European application influenced the formulating of the national Health for All programme. The main principles of this programme are:

- consistency
- emphasis on equity in health
- importance of community participation and commitment
- emphasis on prevention and health promotion
- attention to all factors of health, not only to health care services
- cooperation between different sectors of administration
- health service reform, and
- international cooperation.

In 1982 the WHO and Finland signed an agreement whereby Finland would act as a "pioneer country". According to the agreement, Finland would attend to the WHO strategy in its own health policy planning, make a serious commitment to that planning and openly exchange the experience thus obtained. As a part of the international health policy follow-up, the WHO Regional Office for Europe conducted in 1991 an international review of Finnish health policy. On the basis of the feedback of that review, Finland's national programme was revised, and the total process was evaluated in various international health policy meetings.

The WHO Regional Office for Europe has played a prominent role in the promotion of health. The 1986 Ottawa Declaration is generally regarded as the launching point. The Ottawa Declaration emphasizes the role of policy as a factor promoting healthy choices. Healthy choices can be promoted by creating health-supporting living environments, through the community's own actions, by improving the individuals' health capacities and by reforming the health services. These ideas, even if not so clearly formulated, were already included in the Finnish health policy of the 1970s. At the same time, the WHO adopted the term "healthy public policies", referring to all public sector health-affecting actions.

4.1.2 European Union health policy being formulated

In the European Union, health matters have been and are still treated as a part of the internal market. The four freedoms characterizing the internal market (mobility of capital, work, services and work force) also apply to health care. Therefore many aspects traditionally included in Finnish health policy, such as registration of pharmaceuticals and medical professional, are regulated by that Directorate General of the Commission which deals with the internal market. The Europe against Cancer programme was launched as early as 1986, followed by the first aids programme but these were special campaigns. However, the cancer programme contributed to the fact that the Directive related to the diminishing of the concentrations of the detrimental substances in tobacco products as well as that related to the respective warnings were approved as a part of the Union internal market process.

Through the Maastricht Treaty the Commission obtained a legal basis for treating health issues as public health issues. According to article 129 of the Treaty, the Union shall promote the prevention of diseases and the cooperation between the member states, attending to the health protection requirement in all its actions. The very same year, the Commission issued a Public Health Notification, constituting the public health framework of the Commission. The framework programme outlines the Commission's general public health plan until the year 2000. In 1995, the Commission implemented an

interesting and innovative project by compiling the information about all health-related actions of the different Directorates General although it did not make any actual evaluation of these actions.

Finland considers that public health issues constitute an important but only recently developing area of the European Union operations. Since its early membership, Finland has underlined a comprehensive line of action in stead of disease-oriented programmes, emphasizing the importance of fighting disparities in health, the evaluation of health impacts caused by the economic depression and changes as well as the introduction of mental health issues in the Union agenda. Finland's aim is to include alcohol among the health issues. In health care data processing and communications, Finland has good international potential. Unlike the World Health Organization, the Union has, if needed, both the possibility to create internal legislation and the economic resources for implementing public health policies.

4.2 Basic strategies and priorities

Until the 1970s, Finnish health policy consisted mainly of the gradual developing of the various service system sectors. The more comprehensive approach, whereby the measures external to the service system were seen as integral components of the health policy, was adopted as late as in 1985 as a part of the Health for All by the Year 2000 programme, a programme of long-term health policy objectives and operations.

The objective of the health care service system is to provide sufficient service for a reasonable price or free of charge to all citizens irrespective of their domicile or social situation. The respective measures include the health care services provided by the municipalities, and the decreased price of other health care services through health insurance reimbursements. The milestones in the development of municipal services include the establishing of the maternity and child health clinic network and school health care system before and after World War II, the building of the central hospital network in the 1950s and 1960s and the development of the health care centre system in the 1970s. The purpose of the health care insurance established in the 1960s is to support the community care services though reduced user costs.

In the late 1970s and 1980s, the main objects of the reform and development were occupational health care, rehabilitation and dental care. Efforts were made to make occupational health services available to all persons in employment. Dental care services provided by health centres were increased, and the costs incurred by young adults in private dental care were included in the health insurance reimbursement scheme. The rehabilitation legislation was reformed in the early 1990s but the contents of rehabilitation were developed and the resources allocated to it were increased already earlier.

The period of growing and more versatile supply and increased service utilization lasted until the end of the 1980s. The regional disparities in supply, availability and utilization became smaller and were better allocated than in the 1960s and 1970s. Increasing resources made it also possible to develop the quality and contents of the services. Particular attention was paid to preventive measures and early diagnosis of the diseases. At least part of the improvement in public health was due to the developed service system.

Health aspects and the promotion of health have been considered in the various sectors of social policy since the 1970s. However, it was only in the 1980s that a more comprehensive health-oriented social policy started to grow through the Health for All policy. Measures were taken to diminish environmental health risks through legislation, norms and other directive actions. Efforts were made to direct the living habits of the population towards improved health. The health care service system took part in the preventive work both on the population level and by providing individual services.

Health policy environment in the 1990s

The operative environment of health policy has radically changed in the 1990s. The principal factors include an exceptionally deep economic depression, difficulties in the public finance, the reform of the state subsidy system which affects the relationship between the municipalities and the state, the changes in the management systems in public administration as well as international developments, especially the European integration and the turmoil in Finland's neighbouring areas.

The Health for All programme was reviewed in the beginning of the 1990s, taking the changes in the operative environment and the development in the population health into account. The objectives set included the reducing of health disparities between population groups, maintaining and improving the functional capacities of the population, cooperation in promoting preventive health policy, the development of economy and efficiency in health services, development of health care personnel and health care management as well as promoting the involvement of the citizens. These were the points that laid the foundations for an extensive cooperation programme, discussed by the Government in late 1992.

Reducing the disparities in health between population groups

Numerous health disparity studies have been made, allowing us now to describe and analyze the problem from versatile points of view as well as to follow and evaluate the consequences of the policy implemented. There is still a great need for research in this area, and the Academy of Finland has decided to establish a research project concentrating on health disparities, starting to work in 1996.

A significant part of the health disparities between the different population groups are based on differences in material and mental resources. Social policy aims at promoting equity in well-being by supporting especially those who are the most disadvantaged. The difficulties in public finance have lead to decreased social income transfers whereby the relative situation of the population living on those allowances has become weaker while its share of the population has grown. One objective of social policy has been to find solutions to the problems at an early stage, which also makes the solutions less expensive. An important step taken in the 1990s is the determined development of preventive social policy. In 1995, the national plan of action for preventive social policy was completed. On municipal level, the development of preventive social policy has been promoted since 1993 through a municipal project supported by central government.

Many known health risk factors and risk behaviour differ by social status and education of the various population groups. Such factors include nutrition, smoking and alcohol consumption. The population group with the best education has most benefit from the health education and information related to these factors. Comprehensive social policy actions may have more extensive effect so that also the worse-off can benefit from them. In the 1990s, social policy measures have greatly contributed to the progress made in terms of reduced smoking and the promotion of healthy nutrition whereas the potential of social policy is limited in alcohol policy. This may be reflected in the increased disparities in alcohol-related problems between the population groups.

Cooperation supporting preventive health policy

Both national and local-level cooperation promoting preventive health policy has been developed. The preparation, implementation and follow-up of the revised Health for All strategy have contributed significantly to the intensified cooperation between different sectors of administration and other health policy operators. In order to formulate a model for the municipal level cooperation, the Ministry of Social Affairs and Health, a federation of municipalities, the National Research and Development Centre for Welfare and Health and seven individual municipalities carried out a municipality level Health for All 2000 project in 1994 and 1995. New cooperation platforms established include those in accident prevention and the promotion of physical exercise.

Improving the economy and efficiency of health services

One of the main objectives of the 1993 state subsidy reform was to improve the economy and efficiency of health services. Due to the other concomitant changes, it is difficult to estimate the impact of the actual reform. The structural change of the service system is seen as the major measure towards better operative economy. In order to promote this, a group of five experts was assigned the task of preparing proposals for dismantling overlapping operations and for organizing an optimally efficient regional system in specialized health care. The studies have lead to noteworthy rationalization which is still being implemented. At the same time, the operations have been intensified though internal organizational measures both in specialized and primary health care. The latter, in particular has been implemented through the introduction of the so-called population responsibility model.

Participation of the public in the promotion of health

The foundations for the citizens' participation in health promotion are laid by the Act on patient status and rights and by the fundamental rights reform. They confirm not only the citizens' right to get the necessary services but also the right to health promotion and protection. The Ministry of Social Affairs and Health has supported the public's activities aiming at the promotion of their own and their community's health by implementing and financing local development projects, by producing incentive and learning material and by giving information and training. The cooperation with the public health organizations has been intensified.

Significant actions have thus been taken in the priority areas of the Health for All by the year 2000 revised strategy for cooperation. Most of the 73 individual measures included in the strategy have been fully or partly implemented. The impact of these actions is not necessarily seen in the short term. The most clearly seen change is the improvement of the service system economy. Many indicators that describe the effect of pre-

ventive health policy also show favourable development whereas no progress has been made in reducing the health differences between the various population groups.

4.3 Preventive health policy

4.3.1 Health promotion

Municipalities, civic organizations, public health research institutes and the Ministry of Social Affairs and Health are the principal operators in health promotion. The municipalities have the basic health promotion responsibility, and they can benefit from contribution made by the civic organizations. The research institutes and the Ministry of Social Affairs and Health provide the information, knowledge and material conditions for the operation, and attend to the national operative programmes in collaboration with the civic organizations. The dialogue between the population, the organizations and the authorities is an integral part of the Health for All programme.

The municipalities use a lot of their own resources in prevention and health promotion activities. On a national level, efforts have been made to develop models which would direct the basic municipal resources to the most cost-effective health promotion measures. Nationwide health promotion is financed by the anti-smoking and health education funds based on the Tobacco Act, by the funds allocated to measures to reduce alcohol problems as well as by the funds reserved for this purpose by other parties.

The national health promotion financing is allocated to important health promotion research projects as well as to nation-wide events and training. The projects focus on principal problems in health and social welfare promotion. In addition to important public health issues, national support and attention has been paid to the unattended needs of special population groups. Research and teaching in health promotion has been mainly financed through the normal research and teaching sources.

Health promotion has been based on disease categories, risk factors or living environment, or on some combination of the above. Home, school, the place of work and community (municipality or its part) constitute the units of living environment which have been focused on. Important community level programmes include the provincial projects and the Healthy Municipality project. As a consequence of the economic depression, additional resources were allocated to the research on the health impacts of marginalization and to experimental preventive programmes.

Smoking prevention and reduction of involuntary smoking

Finland is a pioneer in formulating a health-oriented tobacco policy. The 1976 Act on reducing the smoking-related health problems has been an international example. The tobacco policy measures chosen in Finland include health education, price policy, smoking and marketing limitations, product control as well as research and follow-ups. Health authorities are responsible for the implementation of all other aspects of the tobacco policy except taxation. As a result of the first-phase legislation, the level of adult smoking in Finland was the lowest in all Europe in the early 1990s. However, Finnish young people start to smoke quite early by international standards.

Certain first-phase legislation measures are still valid, such as the responsibility of the government and municipalities to promote health and non-smoking habits, and the regulation and control of tobacco products. The main objective of the 1995 Tobacco Act is to protect the population from smoke exposure at work and increasingly also in public premises. Another important objective is to delay and prevent smoking and smoke exposure among the young, as well as to reduce smoking in the environment of the young. The measures among the young include non-smoking schools, intensified prohibition of indirect tobacco-related sales promotion and the prohibition of selling tobacco to the under-18-year-olds.

When passing the new contents of the Act, the Finnish Parliament insisted that it should be developed so that in the future also restaurants provide non-smoking areas for their customers. It must also be considered whether tobacco smoke should be included in the list of carcinogenic substances. The Parliament also requested that the health promotion resources be increased in order to prevent the early smoking of the young.

Alcohol and drug policy

The basis of the Finnish alcohol system remained unaltered from the abrogation of the Prohibition Act in 1932 until the new Alcohol Act took effect on January 1, 1995. All commercial activities related to alcoholic beverages were concentrated in the state-owned alcohol company the Alko-Group Ltd. The alcohol company also acted as the public alcohol authority, granting the manufacturing permits, serving licenses and beer retail sale licenses as well as controlling and exercising enforcement related to these operations. The alcohol company also engaged in social, economic and biomedical research. The supervisory board of the company was an important decision maker in alcohol policy.

Due to Finland's EEA agreement and membership in the European Union, the Finnish alcohol system, along with the respective legislation, has undergone many changes. Except for the retail sales in strong alcoholic beverages, all other monopolistic aspects of alcohol trade have been dismantled. The state-owned alcohol company, the Alko Group Ltd., has the sole right to sell all alcoholic beverages containing more than 2.8 percent of ethyl alcohol by volume. The fermented alcohol beverages containing the maximum of 4.7 volume percent of ethyl alcohol constitute an exception whereby the provincial administration can grant the respective retail licenses for grocery stores, kiosks and service stations. There are no longer any monopolies in alcohol industry.

Another major change is constituted by the establishment of the new agency, the National Product Control Agency for Welfare and Health, responsible for public authority measures in cooperation with the provincial administrations. As of May 1, 1996, the information, education and research operations will be under authority of the Ministry of Social Affairs and Health.

During the membership negotiations with the European Union, it was agreed that Finland can impose much larger restrictions than the other member states to the tax-free sales of alcohol imported by tourists. This is an exception, and negotiations to prolong it are conducted during 1996.

Although a member of the European Union, Finland has been able to retain its alcohol policy as a part of social and health policy. Finland has also been able to continue its principal alcohol policy measures, the control of availability and taxation. The Commission has also approved the Finnish retail monopoly. This way Finland can continue to limit the availability of alcoholic beverages. The protection at the borders which is higher than in other EU countries as regards the imports by private citizens promotes to maintaining a high level of taxation.

Finnish drug policy is based on international multilateral treaties related to narcotics, all ratified by Finland. International cooperation in narcotics issues requires active participation by the UN member states on a government level. The extensive European Union cooperation is a new feature.

As far as it is possible, the preventive narcotics abuse work is connected with the prevention of all forms intoxicant abuse. In drug abuse prevention, close cooperation between the different sectors of administration and various organizations and civic groups is mandatory. The cooperation between the social and health authorities on one hand and the law enforcement and judicial authorities on the other hand is of major importance. Drug prevention work is also carried out by the public education authorities, various organizations and the church.

In drug policy, the objective is to prevent and reduce narcotics abuse through control measures which should not cause unreasonable disadvantages to the drug abusers. Such disadvantages might include stigmatization or social marginalization. Finland has adopted a strict but also a very pragmatic and low-profile drug policy. The drug issue has not been utilized for political ends.

In accordance with the narcotics legislation which took effect as of the beginning of 1994, every effort is made to refer the drug abusers at an early stage to such treatment that would prevent drug abuse and the deterioration of the respective problems. Drug abusers can use the same treatment and auxiliary services as the rest of the intoxicant abusers. The new legislation makes it possible for an abuser convicted for a narcotics offence to opt for treatment in stead of serving the sentence. For this purpose, there are units of intoxicant abuser care that are specialized in the treatment of drug abusers. Besides the population-targeted preventive measures, the drug policy objectives will include the reduction of the problems related to drug abuse.

Narcotics issues have also been discussed by the Council of State, and on February 28, 1996 the Ministry of Social Affairs and Health appointed a committee to prepare a proposal for a national drug strategy. The committee should complete its work by the end of 1996.

In future, the environment for the preventive intoxicant abuse work will be much more demanding. The supply side can no longer be controlled as efficiently as in the past, and therefore an additional input must be made in preventing and reducing the demand of intoxicants.

In municipalities, the resources allocated to this kind of preventive work have been cut quite radically. The relevant personnel has been dismissed and many of the remaining employees have been assigned other responsibilities in addition to their former tasks in intoxicant abusers care. These tasks are also taken care of by many organizations, and therefore there is great variation as concerns the focus of the operations and the resources available for it. In order to develop the community-level preventive work, it is important to intensify the cooperation between the various sectors of municipal administration.

The temperance movement and the respective organizations have undergone a significant change during the recent years. The aim of the reorganization has been to cut overlapping activities, to crystallize the mis-

sion of the organizations, to intensify the utilization of their resources and to reform the modes of operation.

Nutrition policy

Owing to extensive and consistent nutrition planning, many aspects in the Finnish eating habits have developed to meet the objectives set. During the past fifteen years, various sectors of administration have collaborated in determining uniform objectives for public nutrition as well as for developing the various sectors of nutrition, the main target in all of them being the promotion of health.

The progress made in nutrition is based on improved mass catering systems, on the new attention paid to nutrition aspects in the food industry and in the related regulations and control, including the policy of food supplements and package markings, on nutrition research and on the nutrition education within various systems. In 1989, the State Advisory Committee for Nutrition presented its proposal, based on these premises, for the practical implementation of nutrition recommendations.

In Finland, mass catering is exceptionally well directed and organized. Annually, every Finn consumes about 125 meals outside the home. The improved quality of mass catering in the 1980s has had a decisive effect on the progress made in nutrition. Mass catering is being developed in a customer- and service-oriented manner. The objective of food industry is to secure a reasonable-price choice of food stuffs corresponding to the nutrition recommendations. The consumer must get sufficient, correct and comparable information on the products on the basis of the package markings and other sources. Nutrition education has extensive links with the person's situation in each given moment of the life. The development in nutrition research focuses on the nutrition behaviour and mass catering.

Home and leisure time accidents

Owing to long-term determined research and prevention as well as resource allocation, traffic accidents and accidents at work have decreased in the long run. On the other hand, the home and leisure time accidents have increased. It is only recently that attention has been paid to security at home and during leisure, intensifying the education related to the prevention of these accidents.

According to the operative plan of the advisory committee, appointed by the Council of State, for the prevention of accidents at home and during leisure, a co-operation campaign involving various instances was launched in 1993. The campaign has included the preparation of information materials, training and information given to both professionals and the public. The activation of the municipalities was a major objective, and in 1995 the first Finland's Safest Municipality contest was organized. Day care centres and schools have collaborated in the prevention of children's accidents. In future, the focus will be on fall accidents involving the elderly.

Due to the many instances operative in the accident sector, different environments have varying safety cultures. Moreover, this has made accident prevention work less efficient and comprehensive. On the initiative of accident researchers, the Ministry of Social Affairs and Health appointed in 1994 a work group assigned with the task of promoting cooperation in the accident sector. The work group consists of 11 members who represent various accident sectors. The objective of the work group is to develop permanent cooperation in this field and to promote the Finnish safety culture. The actions taken include the organization of national accident prevention days.

Promotion of mental health

The first development measures taken in mental health operations include the steps for the prevention and treatment of the most significant problems, the suicides and the partly related, serious common disease, the depression. Now the objective is to focus on the promotion of mental health. In 1996, a study on the prerequisites of psychological well-being among children and the young will be launched.

In 1992 a suicide prevention project, quite extensive by international standards, was launched in Finland. The project has been implemented in the form of programmes organized under four sectors, including numerous subprojects such as:

- strategies and methods
- professional support services and good care
- mutual support and coping
- the role of mass media in suicide prevention

The suicide prevention project follow-up and reporting takes place in 1996 while the international reviews are conducted in 1997.

Year 1994 saw the launching of a national depression project called "Mieli maastal" - Up with your spirits. The project was divided in responsibility areas, and it is proceeding in primary services, special services, among children and the young as well as in the population responsibility area. Ten responsibility area subprojects as well as numerous research and development projects

carried out independently in various parts of Finland are under way. The project is implemented in the form of research, development, training and health education, and it will last till the year 1998.

Sexual health and human relations

The main lines of action in promoting sexual health include:

- promoting the education related to human relationships and sex among the young,
- developing the education related to human relationships and sex as well as sexual councelling within the health care services
- developing the family planning services and
- prevention of the HVI infection and other sexually transmitted diseases.

Education in human relationships and sex was included as a health education focus area for the first time in the national public health plan for 1980-1984. Many studies have been made on the sexual awareness, attitudes and behaviour of the young, on adult sexual life and the changes that have taken place. Much supplementary training for professionals as well as many nation-wide and local information programmes have been organized by different instances. The Ministry of Social Affairs and Health has published a leaflet on sexual issues, sent annually to the 16-year-olds. The Erotics and Health report by the Advisory Committee for Health Education published in 1992 launched an extensive public debate.

During the past twenty years, a favourable trend can be seen in public sexual health. People are more satisfied with their sexual life than they were in the early 1970s. The sexual equality of men and women has increased, and their mutual expectations are met to a larger extent than was the case earlier. The number of abortions has decreased every year, and today's figure is only a half of the peak in 1973. Abortions among the young and teenage pregnancies are rare - the situation is very good by international standards. This also applies to the HIV situation.

Prevention of communicable diseases

A new Communicable Disease Act took effect in 1987, replacing the old acts on vaccinations, tuberculosis and venereal diseases. In Finland, the prevention of communicable diseases has been based on sufficient and open information, relying on the awareness and responsible behaviour of the population. It has been a conscious choice to avoid coercive measures.

The public trusts in the preventive health care work is shown by the universal top-level coverage of the child immunization programme; the coverage of the different vaccines included in the programme varies between 96 and 99 percent. For example, the children's Hib vaccinations started in 1986 have resulted in an almost total eradication of meningitis among Finnish children. Efforts are made to reduce the vaccine side-effects, as well as to introduce new vaccines if they can significantly reduce the problems caused by the communicable diseases to children and their families. The immunization of the adult risk groups is not as comprehensive, but these operations will be intensified.

In order for the prevention of communicable diseases to be successful, accurate and up-to-date information related to their occurrence, frequency and risk factors is needed. Such information is gathered on the basis of the communicable disease notification and registration procedure, reformed in 1994 and introduced in 1995. The central register is maintained by the National Public Health Institute, and the regional registers by the hospital districts. Reliable statistics constitute the foundation for assessing the efficiency of the preventive measures and can indicate the problem areas where intensified prevention is needed. To quote an example, in 1995 the number of diagnosed cases of syphilis increased, resulting in vivid reactions in the internal information exchanged between physicians. The identification and appropriate treatment of a communicable disease which was thought to be almost eradicated could thus be accelerated and intensified.

As concerns the HIV infection and other sexually transmitted diseases, openness constitutes the main principle of education work. Every year, all 16-year-olds receive a leaflet mailed personally to them. The leaflet discusses the issues related to love and responsibility which occupy the minds of the young, and at the same time they receive information about the methods and importance of the prevention of sexually transmitted diseases. The age-related social and physical maturing is supported so that the young can identify their own personal responsibility and personal rights in dating - including the right to abstain from sex. The schools' work aiming at disease prevention is of primary importance, and such work is supported and encouraged.

4.3.2 Occupational health service

About 80 to 90 % of the Finnish wage-earning population is covered by a systematic occupational health care service system. Finnish labour protection and work safety is also quite advanced, and therefore Finland has been

able to reduce the number of work-induced diseases, occupational diseases and accidents at work.

The objective of the Occupational Health Care Act (743/78) is the prevention of work-induced diseases through improved working conditions and the elimination of health risks caused by the work or work conditions. According to the Act, occupational health care is used for the prevention of factors that constitute a risk for the health of the employee, related to the workplace conditions, work methods and environments. The occupational health care measures aim at creating safe and healthy working conditions as well as at maintaining and promoting the working capacity of the employees. The employer is responsible for the implementation of preventive occupational health care measures in collaboration with the health care professionals.

One major objective of the development strategies is the intensification of occupational health care in the fields with known problems and numerous health risks. The development strategies are grouped in three main categories: the general development of occupational health care, the development of the tasks and contents of occupational health care and the promotion of the operative conditions of occupational health care.

The general occupational health care objectives include the promotion of the overall health and functional capacities of all working life participants, a fully comprehensive occupational health care service system, emphasizing cooperation and participation principles and a multidisciplinary approach in occupational health care. The premises for the work are the working population's health problems in a changing labour market as well as the needs arising from that change. It is essential that the effects and results of the operations are assessed.

National working environment programmes and the reform of the work safety legislation in 1988 have also contributed to the contents of occupational health care. The so-called preventive labour protection is especially intensified by the Work Safety Act. Safety and health factors should be considered already in the planning phase of work. The regulations concerning the mental factors as well as those related to genetics and the protection of the foetus require new skills and knowledge from the health care professionals engaged in occupational health work.

In 1995, a reimbursement reform was made in occupational health care, and this has changed the financing of the operations, tending to emphasize the state subsidy aspect. The financing is based on financial needs determined on the basis of good occupational health needs. A certain cost limit per employee is calculated for the services, and the employer is reimbursed for the costs incurred for arranging these services in the limits of the above maximum sum per employee expressed in Finnish markka. Since different workplaces have different service needs, the 50 % of the costs incurred are reimbursed on the basis of the service need, respecting the maximum limit set. This is a means of cutting costs and keeping the reimbursement system flexible to meet different kinds of service needs. Owing to the financial reform, occupational health services can now be planned to meet the needs of the workplace and to secure the measures that are necessary to maintain the working capacity of the employees.

4.3.3 Environmental health care

The recently published WHO report "Operative plan for environmental health in Europe" outlines the means for improving the healthiness of the environment. The report wants to see environmental health from a new perspective, and it lists the political means to improve environmental health. The most important means include the development of a environmental health information system, assessment of environmental risks with health impacts, control measures, development of environmental health services as well as information and health education. These means are also applied in the Finnish environmental health policy.

In environmental health care, one important objective is to improve the health quality of living environments. To meet this objective, the development work continues on the measurement methods aiming at improved health quality of indoor air.

Health protection will be promoted to prevent the health problems deriving from the environment, household water supply and foodstuffs, and the assessment of environmental health impacts will continue in the spirit of the respective legislation. The occurrence of typically Finnish environmental health risks will be studied, and to eliminate such risks, an operative plan for environmental health care will be compiled.

Food poisonings and water-borne epidemics will be followed though a comprehensive system which will also support preventive measures. To meet this challenge, the food poisoning follow-up system will be reformed in collaboration with the National Public Health Institute and other authorities involved in food control.

The environment contains an increasing number of chemicals, and therefore the respective risk assessment is intensified in accordance with the new EU legislation on chemicals. In chemicals control, the operative condi-

tions of the National Product Control Agency for Welfare and Health are strengthened to meet the new demanding EU risk assessment requirements.

Besides the environmental policy measures, the prevention of environmental diseases should also be based on the activeness of private citizens, and these activities should be encouraged. This is best done by increased information. Health authorities can give more information about the health risks in their respective areas of competence, and local information about health risks can be given by the municipalities. The role of the civic organizations in informing the citizens could be intensified.

Due to the extensive range of environmental diseases, the health care system is faced with a new challenge in diagnosing these diseases. The basic idea in the diagnostics and treatment of environmental diseases is that high-quality services must be available to all clients within a reasonably short period of time. Simple environmental diseases can be diagnosed and treated within the non-institutional health care system whereas the diagnostics and treatment of serious environmental diseases could be concentrated in the specialized outpatient clinics of the central hospitals.

4.4 Health services

4.4.1 Development of the service structure

In 1992, the service structure work group of the Ministry of Social Affairs and Health published an extensive operative programme until year 2000 with the objective of reforming the service structure in social welfare and health care. The regional and municipal review work started in 1993, and the programme was launched. The objective was to look for means to secure high-quality services with reasonable costs in view of the aging population and growing service needs.

Most of the reforms proposed by the review group can be implemented locally by the municipalities and municipality groups. Their practical implementation depends on the operation of the municipalities. Institutional care must be reduced, non-institutional and mixed-form care at the same time increased, and housing conditions be changed to support social and health policy objectives. It is an universal tendency to shift the focus on non-institutional care, an objective met by different countries to a variable extent.

Many of the recent changes in health care show a desired tendency. Institutional care has been efficiently dismantled, and non-institutional community services have developed and increased, yet not in proportion to the dismantling of corresponding institutional care. Contrary to the objectives, however, personnel resources have not been transferred to non-institutional care which has been increased by intensifying the operations. Various mixed-form services, especially those targeted to the aging, have clearly grown.

During the years 1989-1993, the figures related to general practitioner visits, hospital days in hospital wards, home nursing and dental care have remained at the previous level. Those in preventive health care and home visits have decreased whereas the number of short periods of treatment at the health centre wards has grown. As regards the quality of the services, it is worth mentioning that during the past tree years the health care centres have had a stable permanent personnel. Together with the population responsibility approach, this has contributed to continuity in the patients' treatment relationships.

Specialized health care has undergone larger changes than other sectors of health care. The number of hospital beds and hospital days has considerably decreased in specialized health care. Correspondingly, the number of out-patient visits in specialized health care has increased: during the period from 1989 to 1994, the number of visits grew from 4.3 to 5 million visits. The number of hospital days in psychiatric clinics has decreased more rapidly than in other hospital. The number of beds in psychiatric health care has diminished, and at the same time, the periods of treatment have shortened. However, the non-institutional services in psychiatric health care have not developed in proportion to the decrease in institutional care.

At every level, he changes have caused great pressure on the health care personnel. While the resources have been reduced, the service objectives have remained unchanged, or the requirements have even been increased.

4.4.2 Privately provided health care

Reviewed in terms of all parameters, the private practitioners' share of all services provided has diminished during the past few years: not only the number of patients and visits but also the costs have diminished. In 1994, 3.2 million visits to private practitioners were made, 742,000 visits less than in the turn of the decade. The same tendency is seen in the privately provided examination and treatment services (such as laboratory and X-ray examinations) whereas the use of privately provided dentist services has grown; the number of patients and visits has increased and costs have grown.

4.4.3 Rehabilitation

The nature of rehabilitation can be medical, occupational, social or educational. The rehabilitation of the handicapped or disabled is organized by the health care and social welfare sectors, the Social Insurance Institution, education and labour authorities as well as the insurance and pension institutes. Occupational health care is responsible for the workplace operations aiming at maintained working capacity. Moreover, all authorities organizing rehabilitation services have a statutory obligation to collaborate in rehabilitation issues as well as to direct the client in need of rehabilitation to the correct services.

Furthermore, the rehabilitation of war invalids and front veterans is organized on the basis of separate legislation. In 1995, over 400 million markka was used for these rehabilitation operations.

In 1994 the Council of State gave a report on the impacts of the rehabilitation legislation reform and the development of the rehabilitation system (Publications of the Ministry of Social Affairs and Health Care 1994:3). The report looked into the changes caused by the rehabilitation legislation, effective since 1991, in the allocation of the rehabilitation services between different population groups, in the client situation, in the functionality of the rehabilitation system as well as in the distribution of the rehabilitation costs between the various instances organizing rehabilitation.

The objectives related to targeting have not been met, as regards the rehabilitation services provided for those presently working or wishing to enter the worklife. It has also been observed that the persons with metal or drug abuse problems are the major groups not reached by the rehabilitation services.

4.4.4 State subsidy reform

The main objectives of the 1993 state subsidy reform were to enhance municipal autonomy and to promote economy and efficiency in their operation. The aim was to secure that municipalities have sufficient resources to organize the statutory services. The reform offered the municipalities a new possibility of organizing their social welfare and health services in a desired manner. At the same time, the cost-based state subsidy system was replaced by a calculatory system whereby the state subsidies are determined on the basis of various need factors in each municipality. By retaining the system of national plans, the Council of State was reserved the right to define the main principles in social welfare and health care development.

Studies on the impacts of the state subsidy reform have been carried out by both the Ministry's own and outside research institutes. Many aspects of the evaluation of the economic and other effects of the reform are to be completed. The assessments are blurred by the fact that the reform coincided with a moment in the economical cycle in which the municipal economies were in considerable imbalance. Some statistical systems in social welfare and health have also been modified, a factor that makes the evaluations more difficult.

On the basis of the costs calculated per each municipality it seems that cost differences between various municipalities have not grown as was expected prior to the reform. The differences in operative costs between the municipalities have remained almost the same. In 1994, the highest costs were almost 2.3 times as high as the lowest costs, the corresponding relation in 1993 being 2.4. However, it is not possible to evaluate the changes in services on the basis of their costs, nor to know whether the disparities in their availability have increased.

The major changes in the number of health care personnel took place during the transitional phase of the state subsidy reform, coinciding with the deepest phase of the economic depression. From 1990 to 1994, the number of personnel in the municipal health care sector reduced by 4.4 percent. However, municipalities have made efforts to continue the employment of the personnel with a permanent contract. Natural reductions, decreased use of substitute personnel and cuts in holiday pays have been the methods of cutting personnel costs.

Owing to the state subsidy system reform, municipalities have better possibilities to organize their health care through privately provided services. The municipalities have acquired services not only from social welfare and health care organizations but also from operators providing commercial services, such as private medical centres and laboratories. Contrary to what was anticipated, the municipalities have bought less services from the private sector, replacing them partly by extended municipal services. Due to the state subsidy reform, municipalities have less funds available, and this has contributed to the decrease in the number of private services bought by them. It has turned out that the municipalities do not encourage competition between the various services any more than they did prior to the reform. In health care, such competition is thought to provide most benefit in laboratory and X-ray services, operative services as well as in the acquisitions of machines, equipment and various aids while it seems that municipalities do not wish to encourage the competition between specialized health care services.

4.4.5 Health care expenses and their structure

The development in health care can be assessed on the basis of the GNP share of operative health care costs. In 1960-1990 the GNP share of health care costs rose from 4 to 8 percent, and in the early 1990s, the growth has been so rapid that Finland exceeded both the average OECD level and that of the other Scandinavian countries. However, the growth in health care's GNP share is due to the fact that the GNP has decreased. In real terms, the GNP share of health care decreased by almost 12 % in 1991-1993.

The structural changes in health care are reflected in the distribution of health care costs. Between 1970 and 1985, the share of treatment in hospital wards diminished from 50 to 44 %. Correspondingly, the share of non-institutional care (excluding dental care) rose from 17 to 28 %. In 1987-1992 this trend, which was in line with the objectives set, levelled off, and no significant change was seen in these shares. The information concerning the years 1993 and 1994 would, however, suggest that the cuts in health care have triggered structural change: the cost share of the treatment in hospital wards fell to 42 percent and that of non-institutional care rose to 30 percent. Likewise the share of out-patient pharmaceutical costs has started to grow. Unlike all other health care cost categories, the costs for pharmaceuticals rose also in absolute terms in 1992 and 1993.

4.4.6 Health care funding

The share of the public sector (state, municipalities, the Social Insurance Institute) in the funding of the total health care expenditure continued to grow until the mid-1970s. About 84 percent of the health care costs were funded through the state and municipal taxation and the statutory sickness insurance contributions paid by the employers and employees. The share remained practically unchanged until the early 1990s (Table 2).

Since 1991, the share of the state and the municipalities has diminished while that of the sickness insurance and the users, in particular, has grown. The public sector's share of the funding has fallen by 7 percent, and the sources of that funding have changed. The share of the sickness insurance has grown as a result of the increases in reimbursements for pharmaceuticals as well as of the legislative reform concerning rehabilitation that took effect in the end of 1991.

The cuts in the public funding have been offset by an increase in the share of user charges. Part of the growth after 1990 is due to the fact that the right to deduct sickness expenses in taxation was abolished in 1992. The households' medical expenses have further been increased by the fact that certain pharmaceuticals were excluded from the sickness insurance reimbursement system and that the rise in user charges has exceeded the average increase of consumer prices.

It is not yet possible to estimate what impact these changes have had on the utilization of the services. In 1991-1994 the number of visits to physicians decreased, but considered in relation to socio-economic factors, equity in the use of medical services according to the needs seems to have prevailed, even during the depression experienced in Finland. However, it is disquieting that almost the entire decrease in the use of medical services seems to have taken place among the persons with a long-term disease.

The changes in funding have also influenced the distribution of the funding by income bracket. As a whole, the change in health care funding in the 1990s has shown a tendency of benefiting the higher income brackets. This is due to the structural changes in the

▶ *Table 2.* **Changes in shares of funding (%) of health care in 1990-1994**

Source of funding	1990	1992	1994*
State	37.2	35.0	29.2
Municipalities	35.8	33.1	33.0
Sickness insurance	10.8	11.2	13.0
Public funding	83.8	79.3	75.2
Users	12.6	16.6	20.8
Others*	3.6	4.1	4.0
Total	100.0	100.0	100.0

* Assistance funds, employers and private insurance

Sources: Cost and funding of Finland's health services, Social Insurance Institution 1995

financing system rather than to the changes in the sources of funding themselves.

4.5 Preventive social politics

When outlining its strategies, the Ministry of Social Affairs and Health has chosen the preventive strategy as one of its development priorities. Preventive social policy connects to the elaboration of strategies on two basic levels. A preventive social policy project is under way on the municipal level, and a nation-wide preventive social policy strategy has been elaborated on the national level.

On the national level, the preventive policy challenges relate, for example, to the question how to give better consideration to the social consequences of decision-making in general. In this case, the preventive point of view calls for more extensive operations beyond the sector and administration borders. The premise of the national programme is that all society-level decisions have social impacts. Therefore the Ministry wants to study and develop means which would allow the different Ministries to give more extensive consideration to the preventive point of view.

The municipal and local levels usually share the basic objectives of national social policy. However, the operative conditions of local social policy have changed during the recent period of transition. The emphasis on non-institutional care in the service structure, and the large-scale social problems underline the need for a more comprehensive responsibility in social issues. The objective of the experiments carried out as part of the municipality-level preventive social policy project is to increase awareness of the contents and significance of the preventive policy, as well of the social consequences of municipal decisions. For this purpose, many projects employ municipal managers and council members who, for their part, are thus developing a new kind of culture in decision making. The other important premise is constituted by the operations that cross the sector and administrative boundaries whereby the professionals in social policy, health policy, technology and construction create new platforms for planning and decision-making.

4.6 Measures with health impact in different administrative sectors

4.6.1 Ministry of Education

In the early 1990s, the development of primary and secondary education has been characterized by the delegation of authority and an increase in discretional options as concerns the syllabus-related decisions. It is entirely in the authority of the party maintaining the school to decide how to allocate the funds. The decisions made by the Council of State concerning the syllabus of the comprehensive school and the upper secondary school (834/93 and 835/93) gave the schools more discretion in all subjects, thus diminishing the obligatory part. This way the nation-wide obligatory number of physical education lessons diminished in the lower level of the comprehensive school from 15 or 16 lessons to 12 lessons and in the upper level from 7 to 6 lessons. At the same times the schools were also given the option to increase the number of obligatory physical education lessons. To some extent, this option has been utilized. In the comprehensive school, health and hygienics continue to be taught as a part of physical education.

According to the objectives of upper secondary school hygienics, the young should learn to appreciate health and to understand the importance of the effects of lifestyle, physical exercise and the environment as well as to know how the Finnish health care system works. The syllabus principles also refer to the physical exercise outside school and the cooperation with other sports and exercise operators.

To support the implementation of the new curricula, the National Board of Education has published supplementary material and has organized further training. Special attention has been paid to the importance of the correspondingly reformed Tobacco Act as well as to the prevention of drug experiments. Problems tend to accumulate, and therefore the pupil welfare system and the preventive measures, or those taken immediately after the problem has been identified, play a decisive role. As regards disabled pupils, a reasonable number of services is available.

The volume of school and student health care, both required by the Public Health Act, show a downward tendency. Many municipalities have shortened the working hours of the school public health nurses and doctors, and the health care centres have taken over many of the services previously taken care of in schools. Preventive health care and the possibilities to solve psychosocial problems are most affected by the diminished resources. The number of both school social workers and school psychologists is too small. School social workers mainly serve the comprehensive school upper level.

Teaching in university level institutions

Health care education, including the training of physicians, has been intensified so that more attention is paid

to early patient contacts, the patient-doctor relationship and the skills required from a physician in primary health care. As a result of Finland's membership in the European Union, the training programme now includes obligatory supplementary training in primary health, to be completed after graduation. Moreover, in many fields, such as pharmacy, psychology and speech therapy, both the graduate and the postgraduate curricula are being reformed in order to be able to respond to the more complex health problems with new professional skills.

Promotion of physical exercise

The Ministry of Education has launched two projects aiming at improved public health. School children and students constitute the target of "Physically active and healthy school", whereas "Fit for Life" targets the adult population, those between 40 and 60 in particular. The objective is to raise the number of the physically active from 33 % to 43 %, an increase of 150,000.

The Ministry of Education uses its physical education research funds to support the operations and research projects carried out by the scientific community. Most of the funds are channelled either directly or indirectly to operations that promote public health. The scientific community that receives the Ministry's funding consists of six sport medicine centres engaged in research, training, information and service activities. The centres also train the doctors specialized in sports medicine.

Promotion of research

In 1989 through 1995, public health research and researcher training received special Academy of Finland funding under the title Health for All by year 2000.The purpose of the research programme is to support the Finnish Health for All policy. The research programme was prepared in close collaboration between the Ministry of Social Affairs and Health and the Academy of Finland. Initially, it was decided that the research should focus on the disparities in health between the different population groups, the evaluation of the Health for All programme implementation, the service system, the health promoting lifestyles and health-oriented social policy. As the programme proceeded, three additional themes were added by the commission of medicine: evaluation of technologies, epidemiology and other sectors.

4.6.2 Ministry of Agriculture and Forestry

The administrative sector of the Ministry of Agriculture and Forestry comprises the control of the veterinary health care issues. The success in veterinary health care is directly reflected in people's health and safety.

The government is responsible for the prevention of contagious animal diseases, for animal protection as well as for meat inspection in slaughterhouses while the municipalities are in charge of organizing veterinary services as well as of the hygienic control of the animal-derived foodstuffs intended for human consumption.

The legislation related to the foodstuff control, comprised in the whole of the veterinary health care, was totally amended during the EEA period and in connection with Finland's accession to the European Union. This legislation is now totally harmonized with the respective EU legislation.

In virtue of the new hygiene legislation, the respective facilities have an obligation to develop a in-house monitoring system related to the internal operations, raw materials and products. The laws prescribe that the in-house monitoring systems must be approved by the municipalities, who also control their implementation. When implemented by the companies, the in-house monitoring systems based on risk analyses diminish the need for public control. At the same time, a far more developed control expertise is required, which at the moment is not available in the municipalities.

During 1995, the in-house monitoring systems started to operate in an excellent manner in the major facilities. As concerns the future, one of the major control objectives is to introduce the in-house monitoring system to all units referred to in the hygiene laws.

National salmonellosis control programme

The purpose of the salmonellosis control programme is to guarantee the safety of the animal-derived foodstuffs by maintaining the salmonellosis situation of Finnish food production animals and the foodstuffs derived from them at a low international level. To reach this objective, the spreading of salmonellosis in all phases of the production chain is prevented through special monitoring of the critical points of that chain. The programme encompasses the control of cattle, pigs and poultry as well as the meat and eggs derived from them, and it aims at keeping the occurrence of salmonellosis in food production animals and in the foodstuffs derived from them at less than 5 % in each unit, and at less than 1 % on a nation-wide level. In the framework of the national programme, a total of 6,000 lymph node samples of pigs and 3,000 of cattle are taken every year. Moreover, the production hygiene of slaughterhouses and butcheries is monitored with the help of a very comprehensive sample programme.

Import control of the animal-derived foodstuffs

In the EU region, the animal-derived foodstuffs also move freely without regular border controls. Corresponding to the practice followed for domestic food, the control of these foodstuffs takes place in the places of first entrance of the foodstuff deliveries. The control must become an integral part of the in-house monitoring programme in the facility or other unit which is the place of first entrance. The monitoring system of the places of first entrance has been launched in 1995, and it should be quite comprehensive in the near future.

Control of extraneous substances

Every year, Finland prepares extensive extraneous substance control programmes related to the animal-derived foodstuffs, implementing these programmes during that particular year. In 1995 the programmes focused on milk and meat, but already in 1996 they will also encompass fishery products. The extraneous substances also include pharmaceutical residues and the prohibited veterinary substances. The present results indicate that the domestic animal-derived foodstuffs have very little pharmaceutical residues or other harmful substances.

Zoonosis control

In the European Union, zoonosis control is regulated by a special Directive. The major diseases are bovine tuberculosis, brucellosis, salmonellosis, trichinosis and rabies. As regards bovine tuberculosis and bovine and small ruminant brusellosis, Finland has been declared disease-free by the EU Commission. To prevent the spreading of rabies, the EU is financing a wild animal immunization programme, implemented through the use of baits at the Finno-Russian border.

Bovine BSE infection, or the "mad cow disease", and sheep scrapie infection have never been diagnosed in Finland. Since 1988, Finland has taken actions to prevent the spreading of BSE by prohibiting, for example, the imports of live cattle from England.

Low-fat milk and the schools

On Finland's initiative, low-fat (1 %) milk was introduced into the EU school milk programme in December 1995. In virtue of Finland's accession treaty, this exception will be valid to the end of 1997

4.6.3 Ministry of Justice

Fundamental rights reform

The laws (969-972/95) which meant a profound reform of the provisions concerning fundamental rights in the Constitution took effect on August 1, 1995. The principal fundamental rights related to social security are included in the Constitution. Each person who is not able to provide for the security which is the prerequisite for dignified human life, has the right to have the basic subsistence security and care. The public authorities must provide the necessary social welfare and health services for all, as well as promote public health.

Previously, the Constitution did not include a corresponding provision concerning social security. The signing of various United Nations, Council of Europe and ILO treaties has engaged Finland to the maintenance and promotion of social security. The section is in harmony with these international obligations. The promotion of public health means preventive social welfare and health care measures, and it also refers to the health-oriented development of social conditions in various public sectors.

According to the Constitution, the public authorities should secure for all citizens a healthy environment and the possibility to participate in the environmental decision-making. Healthy environment means a viable environment, and the conditions of such environment must not cause direct on indirect health risks to persons. Healthiness also includes the idea of a pleasant human milieu.

General reform of the Criminal Law

The amendments to the criminal and certain other laws (578-742/95), comprising the second stage in the general reform of the Criminal Law, took effect on September 1, 1995.

The provisions related to the offences against life and health have been reformed. The new assault provisions draw a parallel between physical violence and mental violence that is detrimental to mental health. The Criminal Law provisions on the offences involving public danger have also been reformed. The principal penal category referred to by the provisions is the public endangering of human life and health.

Previously, the Criminal Law did not contain any specific penal provisions concerning the working life or environment. After the reform, provisions on offences against occupational safety and working hour protection, as well as on work discrimination have been included in the law. Also the principal provisions concerning environmental offences have been included to em-

phasize the great importance of environmental protection.

Drug and alcohol offences

Criminal Law section 50 concerning drug offences took effect as of the beginning of 1994. The administrative regulations concerning drugs are included in the Narcotics Act, likewise in force since the beginning of 1994. Through amendments, the Finnish legislation is now in harmony with the requirements of the United Nations convention on the prevention of illegal trade in narcotics and psychotropic substances. The convention was ratified to enter in force on May 16, 1994 in Finland.

Prosecution or sentence for drug abuse or drug-related offence can be waived if the defendant shows to be committed to treatment approved by the Ministry of Social Affairs and Health. The Ministry of Social Affairs and Health has issued a decision (1394/94), in force as of January 1, 1995 on approved treatment in narcotics offences. Besides social welfare and health care personnel, also public prosecutors and Court members have participated in a training programme related to the drug legislation, implemented in 1995 by the Ministry of Social Affairs and Health.

Prisons

The number of prisoners in Finnish prisons totalled 3,248 in the end of 1995. The number of new prisoners has shown a declining trend, and the proportional share of long-term prisoners has grown. The average age of the prisoners is 32 years. The prisoners have slightly more somatic diseases and conditions resulting from traumata than the average population. The occurrence of severe psychotic mental disorders does not differ from the average but the frequency of less severe mental health disorders is clearly above average. Intoxicant addiction problems and personality disorders are particularly common. More than half of the prisoners have decreased working capacity.

The occurrence of communicable diseases among the prisoners does not differ significantly from the average population. Hepatitis C is quite frequent among the abusers of intravenous drugs but the occurrence of HIV infections among prisoners is not above average.

Although special attention is paid to the hygiene in prisons, the conditions for good personal hygiene are not always sufficient. This problem was pointed out by a Council of Europe committee in its 1993 report on the Finnish prisons.

Special attention is also paid in the prisons to the prevention of drug abuse. Besides health education, the care of the drug addicted has been intensified. Intoxicant-free prison departments and institutions have been established. The basis for the drug abuse prevention is the 1995 review on methods of reducing intoxicant abuse among prisoners.

4.6.4 Ministry of Trade and Industry

Foodstuffs

The objective of the Foodstuffs Act is to secure the healthy quality of foodstuffs and to protect the consumers from health risks and economic losses caused by foodstuffs.

Belonging to the European Economic Area, and the later membership in the European Union as of the beginning of 1995 gave Finland the obligation to harmonize the food legislation with the respective European Union regulations. The Union legislation also includes the objective of protecting the consumer's health. This end is served by numerous regulations which aim at guaranteeing the impeccable health-related quality of the foodstuffs on sale. These regulations include the provisions on the use of additives and extraneous substance residues, those related to foodstuff hygiene, frozen foods and materials in contact with foodstuffs. Markings on packages and the information about the nutrition value help the consumer to choose the preparations that are best suited in view of his health and well-being, considering the individual predisposition to allergies, etc.

Due to public health reasons, Finland has kept in force certain marking regulations which are not included in the EU legislation. These include the food salt content marking and the requirement to mark the substances that cause hypersensitivity. The limits for notifying high salt contents were set already in the mid-1980s for the first time (first in the provisions related to additives and later in the package marking provisions). In 1992, the limits were revised and lowered. According to research made, they have contributed to the decrease in the foodstuff salt contents. It is a prerequisite for the favourable tendency that the salt contents are continuously monitored and that the content limits are regularly revised and lowered.

The success in the nutrition education depends on whether people can in practice use their knowledge. The package markings must be so informative that people can use them to choose the most suitable goods in view of their health. The new Foodstuff Act (361/95) clearly prohibits the making of health-related or medical statements of any foodstuff. The Foodstuff Agency is preparing instructions concerning advertising and sales promotion allegations so that there would be an effi-

cient practical means of dealing with claims that are harmful to health.

Foodstuff control

All laws related to the foodstuff control have intensified the trader's obligation of in-house monitoring. In-house monitoring refers to that part of the foodstuff company's quality system which aims at guaranteeing that both the products and the production, manufacturing and marketing conditions correspond to the regulations. The introduction of the in-house monitoring system increased the control by public authorities, making it more versatile, contributing to the materialization of public health objectives in the distribution of foodstuffs. A member of the European Union, Finland can no longer exercise import control as regards the Union foodstuffs imported from the other members states. Municipal authorities take over the control responsibility. Since their capacities to assume these tasks are variable, the control reorganization is implemented gradually. The Customs Laboratory shall be reserved sufficient operative conditions even in this changing situation.

The Foodstuff Agency has been active in producing public health promoting information material for consumers. The subjects of the published material include fish as nutrition, environmental toxins in foodstuffs, salt and the consumer's possibilities of avoiding the intake of salt through industrial foodstuffs, and the package markings a support to consumer guidance. These topics have also been treated during the so-called food monitoring days, the latest of which was arranged on September 5, 1995 on a national level.

Product safety

The Product Safety Act (914/86) took effect on May 1, 1987, and the application of the legislation was extended in 1993 to also comprehend dangerous consumer services and industrial household products. The temporary sales prohibition and return practice were means added to the control measures available to the authorities. Moreover, the new notification obligation increased the carefulness obligation of the traders.

The objective of the Product Safety Act is to protect the consumers in advance from the hazards related to the use of consumers goods and services. The manufactures and importers carry the principal responsibility for the product safety, and they have to attend to the primary control measures in accordance to the respective provisions. Through the market control, it is the authorities must ensure that the primary control has been taken care of and that only products that meet the regulations are on sale

The Consumer Agency keeps a product registers, intended to be used by the Agency itself and by the provincial governments. Research data and information on the products which the consumers have complained about is recorded in this register. Moreover, the notifications on dangerous products received through the EU are registered. The Consumer Agency is also responsible for recording the accidents at home and during leisure in accordance with the European Union EHLASS system. The EU finances the collection of the data from three hospitals and the Consumer Agency from one hospital. There are 12,000 recordings in the register.

4.6.5 Ministry of the Environment

Air protection

The most important air protection provisions are included in the Air Protection Act (67/82) and Statute /716/82) and the Government decisions issued in virtue of the legislation. In accordance with section 9 of the Air Protection Act, the government can issue necessary general instructions and ordinances related to emissions, air quality and fallout, to prevent a health risk or a health hazard or a significant pollution of the air caused by other factors. The Air Protection Act and the respective normative regulations are applied directly to the operations that involve a risk or air pollution as well as to the permit procedure followed in accordance with the Act on Environmental permits.

The objective of the Air Protection Act is the advance prevention of air pollution. Both the operators engaged in activities involving the risk of air pollution and the authorities referred to in the Act share this obligation.

In the beginning of the 1990s, the most recent knowledge concerning air quality and the respective health and environmental impacts made it necessary to revise the existing norm values. In particular, the range of impurities, the correctness of the concentration levels and the uniformity of the norm value monitoring needed to be looked at. The norm value work group, appointed by the Ministry of the Environment, gave its report and proposal for new norm values in 1993 (Committee report 13/1994).

The decisions related to the containment of traffic emissions have been made under the administration of the Ministry of Traffic and Communications. The limit values concerning the car exhaust gas emissions became more severe in the beginning of 1990 as concerns new car models, and in 1992 as concerns all cars taken for the first time into use. The exhaust gas regulations concerning pick-up vans were tightened correspondingly during the years 1992 and 1993, and those for heavy-

duty diesel motors in 1992, 1993, 1995 and 1996. Limitations related to lead contents in motor petrol were introduced in 1989, and those concerning idle running of cars in 1992.

It is mainly on the basis of these and some related decisions that the sulphur oxide and particle emissions in industry and energy production have been greatly reduced. The permit procedure has helped to control the large-scale emissions to a satisfactory extent. Progress has also been made in the prevention of smell problems although some industrial localities continue to have these problems related to the human milieu. The results attained in the control of nitrogen oxide and ammonium emissions have not been as good. A survey was completed in 1995 on the need and means to limit the nitrogen oxide emissions.

The levels of impurities in Finnish urban air, excluding the total amount of airborne dust, are on an average slightly lower than in most continental and southern European cities of equal size but in Finland there are also air quality problems, especially in the downtown areas of the major cities and in industrial localities

Indoor climate

From the public health point of view it is important that the indoor climate, or the closest environment in which people spend about 90 % of their time, is healthy and pleasant. Indoor climate here refers to the cleanness and other qualities of indoor air as well as to the thermic and corresponding properties of the surrounding surfaces. Indoor climate is deteriorated by the impurities deriving from outside air, from the building and its equipment, and especially from humans and human activities. Indoor climate quality can also be deteriorated by insufficient control of the room thermic conditions, such as too high or low room temperature.

The most serious indoor climate problems are related to radioactive radon gas and tobacco smoke, both carcinogens. Asbestos contained in inside air causes lung cancer and asbestosis. The Tobacco Act and the changes in smoking habits have greatly reduced the exposure to inside air tobacco smoke, and thus also the respective health risk. Today, there is also increased knowledge about the regions that have radon-related hazards. When these areas are constructed, which as such is restricted, radon hazards and their prevention should be considered. The use of asbestos has diminished after the prohibition of its use, but during repairs the indoor air can in exceptional cases contain hazardous amounts of asbestos.

During the past few years, allergic and other problems caused by moulds and other micro-organisms have been common indoor climate problems. There is mould fungus spore everywhere, and detrimental mould grows only if the conditions are favourable for it. The most important reason is the moisture of construction materials and their surface. Such a detrimental situation is usually caused by a water or humidity damage but sometimes high relative humidity of the air creates conditions favouring the growth of mould. The authorities, including the Ministry of the Environment, have given instructions for the prevention of water and humidity damages through problem recognition, correct planning and construction. However, the scope of the mould problem is not yet known, nor the most appropriate remedies in each case.

Noise abatement

Noise has become a serious environmental problem, particularly in the industrialized countries. Noise has increased and spread especially through urbanization, changes in the economic structure and increases in traffic. Environmental noise is caused by various forms of traffic, industry, construction and certain leisure activities.

Information about the exposure to environmental noise in Finland remains insufficient. It is estimated that about a million people live in traffic noise areas.

Noise abatement is based on the implementation of the respective Act (328/87) and Statute (169/88). The legislation requires that both the authorities and the operators causing noise consider noise abatement in their operations. The noise abatement plans made by the municipalities play an important role in the prevention and reduction of noise problems. Communal planning and the evaluation of environmental hazards are other instruments in the prevention noise problems.

Land-use planning

According to section 1 of the Building Act, land areas and their use must be planned in a manner underpinning sustainable development of the natural resources and the environment. The health requirement is separately recorded in section 34 according to which the town plan must satisfy the requirements of health, fire safety, traffic, milieu and beauty.

When the Act on the evaluation of environmental impacts (468/1994) was passed in 1994, the Building Act was also amended. It prescribes that when the community plans are being drawn, both the environmental impacts and community economical, cultural and other impacts of their implementation must be studied to a necessary extent. In the instructions and approval procedures related to planning, health and milieu factors

have played an important role. Sometimes they have constituted the basis for not approving certain plans or parts of them. The Ministry has published studies and manuals on these issues: town and building plan markings and regulations, traffic safety in town planning, handling of environmental hazards in planning.

Land-use planning can be used to influence traffic volumes and the functional possibilities of various means of transportation. This sets a certain basic level for traffic emissions and safety.

Ground water protection

As regards the health aspect, ground water is usually good household water. Finnish ground water does not contain any natural carcinogenic or mutagenic compounds, nor are such compounds created when ground water is turned into household water. Ground water does not have any pathogens either, so that no disinfecting is needed.

The share of ground water and artificial ground water of all water distributed by the public water facilities has continued to grow. Today, that share is 55 %, and it is anticipated to grow upto 75 % by year 2010. In addition, the scarcely populated areas traditionally use both ground and household water. Certain industries, such as food industry, prefer ground water for their water supply.

4.6.6 Ministry of Transportation and Communications

Promotion of safety in road traffic

The traffic accident prevention work is carried out to meet the objectives proposed by the parliamentary traffic committee and later set by the government. The objective is to reduce the number of fatalities to a half by year 2000, the basic level being the 1989 statistics with 734 fatal traffic accidents. Another objective is to remain on a good Scandinavian safety level.

In 1993 the government made a 33-point policy decision on the improvement of road traffic safety, based on the national traffic safety plan for 1993-1996 made by the Advisory Committee of Traffic Safety Issues. All responsible authorities have continued to implement the traffic safety plan. A follow-up report was written in 1996 on the degree of implementation of both the policy decision and the actual plan. The traffic safety situation has significantly improved in the 1990s when the operative programme has been implemented. The economic depression has also contributed to the positive trend; the growth of traffic decelerated and even stagnated.

The major planned measure categories include the diminishing of traffic growth pressure through community planning, promotion of the use of safety devises, improvement of the traffic environment, intensifying of control, support or the regional and local work as well as the organization of life-long traffic education. Most of the proposed action have been or are being implemented. Some things have taken a turn for the worse, such as the diminished traffic control resources of the police.

The Advisory Committee for Traffic Safety Issues has already started to draw a traffic safety plan targeting the years 1997-2000. The plan aims at reaching the objective set as well as to launch and prepare measures that secure conditions for a continuous improvement of traffic safety during the following century and millennium. The effects and costs of different actions are fairly well known. Besides the desired level of safety, however, also other factors influence the traffic decisions, and some of them are contradictory to safety.

Traffic safety work will be increasingly focusing on the regional and local levels. As the state control is diminishing, the provinces and municipalities are motivated to work for improved safety and milieu of their own regions. The interactive component in planning is increased by promoting the cooperation with the local inhabitants and the voluntary organizations who represent them. In municipalities, traffic safety work should be an issue shared by all sectors of administration.

Improving safety in waterborne traffic

In Finland, about 200 to 250 persons are drowned every year. The variation is directly dependent on the summer weather conditions. Among those drowned, about a hundred lose their lives in boat accidents. Alcohol is often involved in the drowning accidents. The most typical drowning accident victim is a drunken man in his 40s or 50s not wearing a life-vest.

Under the Ministry of Traffic and Communications, the issues related to boating security education are taken care of by the Advisory Committee for Boating in collaboration with the National Board of Navigation. Every year, the Advisory Board has organized active and visible campaigns for improving boating safety and promoting good boating habits. The themes of the campaigns have varied but education concerning life-vests has been included every year.

Prevention of environmental hazards caused by traffic

In 1994 the Ministry of Traffic and Communications confirmed an operative plan for reducing the environmen-

tal hazards, involving all forms of traffic. The plan sets the guidelines for the environmental work in this administrative sector, and the implementation of the respective objectives is followed on an annual basis.

From the public health point of view, the major environmental hazards caused by traffic are the road traffic emissions. The noise caused by road and railroad traffic also has some relevance.

The evaluation of environmental impacts and environmental research are being intensively developed under the administration of the Ministry of Transportation and Communications.

4.6.7 Ministry of Finance

Taxation of tobacco and alcohol

The entire tax legislation related to alcoholic beverages and alcohol was reformed on July 1, 1994. The reform was motivated by the EEA treaty on one hand, and Finland's wish to adapt to the EU legislation on the other hand. Previously, the tax on alcoholic beverages was calculated either as a percentage of the retail price set by the alcohol company, or as a percentage of the value of the alcohol company's invoicing in each calendar month. Part of the taxes were collected in the form of the share in the alcohol company's surplus. In the new system the tax on the alcoholic beverages is determined on the bases of the alcohol contents of the product. The tax rate varies depending on the type of alcoholic beverage, i.e. spirits, wine or beer. As a result of Finland's membership in the EU, the taxation system is as of January 1, 1995 completely harmonized with the EU legislation, except that Finland was granted the exception of being allowed to levy taxes on the alcoholic beverages imported by tourists from other member countries.

As of the beginning of 1995, the tobacco taxation was reformed so that the cigarette taxes were raised to correspond to the minimum level required by the EU Directive on the taxation of tobacco products (92/79/EEC). At the same time, the value-based taxes of pipe and cigarette tobacco was raised. In the beginning of 1996, the unit taxes on cigarettes were further increased to prevent the transfer of consumption towards lower price category products. To prevent low-price sales, an equal unit tax was for the first time defined for both cigarette and pipe tobacco, the taxes being 12 markka per kg. To guarantee an equal treatment of all tobacco products and to prevent the entrance of tax-free products on the market, a value-based tax was levied on all other tobacco products.

As a result of the membership in the EU, changes were made in the amounts of alcoholic beverages and tobacco products allowed to be imported by the tourists. Prior to Finland's membership, the tax-free amounts were the same from all countries. Moreover, there was a time limit for tax-free sales, abolished as a result of the EU membership.

Finland's EU membership has clearly caused a noteworthy increase in the imports by the tourists, in particular from third countries. Especially the imports of beer have grown. The elimination of the time limit and the increase of the tax-free amount from 2 to 15 litres of beer have contributed to the growth.

The following table is a comparison of the 1994 imports and 1996 anticipated imports. The 1995 values are based on studies made by Gallup Finland.

If all the alcohol estimated to be imported tax-free would be bought in Finland, taxes amounting to about one billion markka would be levied on it. However, this sum does not represent the loss of tax revenue incurred by the state because the people would not buy this quantity of taxable alcohol. It can be roughly estimated that the state tax revenue loss amounts to about a half of the above sum.

The volume of tourist imports of alcoholic beverages from Russia and Tallinn has distinctly grown, in turn resulting in increased consumption of alcohol. The con-

Table 3. **Alcohol imports in 1994 and 1996**

	Imports (millions of litres)		Imports by country of origin in 1995*	
	1994	1996*	third countries	EU countries
beer	3,5	30,0	26,0	4,0
wine and medium strong products	3,5	8,5	3,5	5,0
strong alcoholic beverages	3,0	7,6	3,6	4,0

* Estimate

sumption of alcohol causes significant social policy and health problems. The consumption also causes direct costs to society, such as those required by social welfare and health care and the police administration. The direct costs incurred by society due alcohol consumption are estimated at 4 billion markka.

In Finland, the consumption of cigarettes shows a decreasing tendency, a result of successful health education. It is, however, estimated that the favourable trend will take an upward turn by the year 1998 if tourism is going to grow and the number of cigarettes allowed to be imported tax-free is raised. If the EU import limits would be directly adopted, this could, in the worst case, increase the consumption of tobacco products as much as by 17 %.

Environmental taxes

Presently, Finland levies the so-called environmental taxes on drink packages, certain oil products, etc. The fuel tax is levied in accordance with the product carbon dioxide contents, and the tax rate levied on low-quality fuels is higher than that on cleaner products.

According to the programme of the present Government, environmental taxes should to a significant extent offset the reduction in the taxes on labour. As regards the environmental taxes, the preparation of the Waste Tax Act has proceeded the furthest.

Customs offence control

During the past few years, the emphasis in the customs offence control has been on the prevention and uncovering of the illegal importation of narcotics. At the same time, the drastically increased illegal imports of alcoholic beverages as well as tobacco and pharmaceutical preparations (doping substances) have required new resources and different kinds of control measures. The boom in the Russian and Baltic traffic, and the customs offences involved, have required a more extensive use of customs offence control measures. The operative control has focused on the prevention of organized and professional customs criminality. In this operation, the customs have increasingly utilized information deriving from the information services, international cooperation between the authorities and new technologies.

In 1995 a total of 89 attempted cases of smuggling of narcotics were uncovered. The number of uncovered illegal import attempts was the highest in tourist traffic, followed by postal traffic. A total of 106 suspects were caught, 33 foreigners of 17 different nationalities. In 1995, 24 Finns were caught on different borders on their way to Finland, carrying a total of 28 kg of hashish and 5 kg of amphetamine.

4.6.8 Ministry of Interior

The intoxicated taken into custody

All through the 1990s, the number of cases where intoxicated persons have been taken into custody have diminished. This is due to the fact that the police has taken into custody only those intoxicated persons who have been a hazard to public order or safety, those disturbing the peace or acting violently. The drunken persons who are not able to take care of themselves, risking to become crime victims or risking their life or health

Table 4. **Narcotics offence statistics.**

Confiscations (grams or numbers)

	1993	1994	1995
Number of confiscations	2,056	2,090	3,053
Hashish	117,077	64,325	147,514
Amphetamine	18,701	9,070	20,123
Heroin	682	1,557	16,117
Cocaine	5	37	66
Kat	23,873	88,233	68,114
Ecstasy (number)	*	-	3,752
LSD (number)	29	2 541	500
Pharmaceuticals (number)	18,507	28,972	16,841
Breaks into pharmacies or pharmaceutical warehouses	101	99	74

because of their intoxication, have also been taken into custody. The police custody practice has not met with unconditioned public approval because in certain areas the intoxicated people are considered to disturb public peace. The motivation for the operative policy chosen, however, is the will of the legislator expressed in the regulations contained in the police legislation. Since restricting a persons freedom is an extremely strong measure interfering with the fundamental rights, the police cannot intervene with any person's rights only because of that person's drunkenness. Since 1969, a person cannot have been taken into custody on the basis of mere intoxication. As a result of changes that have also been made in other laws, there are growing numbers of intoxicated people in public places. After section 58 of the Alcohol Act was amended, being drunk on a public place is as such no longer prohibited.

One reason contributing to the decreased number of persons taken into custody because of their intoxication is the fact that some municipalities have organized temporary shelters for the alcohol abusers. These shelter accept the persons even when they are under the influence of alcohol. When compared with international statistics, the number of persons taken into custody is high in Finland. However, this is explained by the severe climatic conditions as well as by the fact that the number of temporary disintoxication shelters established in virtue of the legislation related to the treatment of the intoxicated does not meet the standards set in that legislation.

Intoxicants and capital offences

The intoxicants play a significant role in crime. Many persons guilty of offences against the person or property have been under the influence of alcohol or other intoxicants while committing the crime. In Finland, capital offences very commonly involve intoxicants. Among the persons suspected of committed or attempted murder and manslaughter known to the police in 1995, 77 % were under the influence of alcohol.

Narcotics offences

The narcotics offences uncovered in 1995 showed a new, clearly growing tendency in all sectors after the slightly levelling trend in the previous year. As concerns the most common narcotics, the quantity of narcotics confiscated was more than two-fold. Besides the narcotics confiscated, investigation has revealed that, for example, hundreds of kilos of hashish have been smuggled into the country. However, these substances have entered the market before the investigation.

The number of persons suspected of narcotics offences has grown by almost 25 %, or to almost 4,000. Proportionally, the growth was largest in the age group from 15 to 18 years. The number of foreigners guilty of narcotics offences rose distinctly.

The number of breaks into pharmacies and confiscations of pharmaceuticals classified as narcotics have diminished. The recent increase in the number of drugs classified as narcotics has not had any effect on this. The number of persons guilty of prescription frauds seems to remain fairly constant.

Criminality related to narcotics has increased sharply during the past few years. Typically, it is hidden criminality which is uncovered not only through tip-offs but also as a results of the surveillance exercised by the authorities. According to international surveys, only 10 percent of all drugs-related criminality is disclosed by the supervisory authorities.

4.6.9 Ministry of Labour

Changes in the operative environment

New forms of work, especially the blurred border between entrepreneurship and wage-earning work and the relative decrease in the number of permanent employment contracts show a clearly visible trend which seems to have intensified during the past few years. The so-called non-typical employment, including part-time and temporary work, hired work as well as remote work and home commuting, has increased. Only 30 percent of new employment contracts have been made for an indefinite term.

According to the 1995 work climate barometer, the four-year persisting trend of hurry and mental pressure starts to be levelling off. There are fewer persons now who think that the pressure has increased. On the other hand, these persons are in a clear majority. At the same time it is estimated that overtime work (both reimbursed and non-reimbursed) has significantly grown. The increase in overtime and work pressure is most distinctly seen in the results concerning the public sector. It now seems that for the first time, the quality and quantity of work start to be reflected in the wages and salaries.

Insecurity and continuous changes will also characterize the labour environment in the future. The demand for increased competitiveness force both the private and the public sector to intensify their operations. As concerns the level of income and employment security, work risks polarization is a consequence of the intensification measures. International competition and integration will have a similar impact on the labour market.

Regulation and development of labour law

Numerous legislative projects are under way, including those related to the overall reform of employment law, more versatile forms of work, employees sent out on missions, training obligation, working hour reform, industrial cooperation legislation, mergers, protection of young employees and annual holiday regulations.

Reform of the working hours legislation

The government's proposal for the overall reform of the working hours legislation should be given in spring 1996. It includes a proposal for a new general Working Hours Act which would abrogate and replace the existing working hours act, as well as the individual acts related to working hours applied to shops and offices, agriculture, janitors and bakeries. The proposed act would also be applied to the work of civil servants employed by the state, municipalities, municipal federations, church and other public bodies if not otherwise prescribed by the Statute. The proposal also harmonizes the working hours legislation with the requirements of the EU Directive on certain issues concerning the organization of working hours.

Labour market services

The personal labour market services, and especially the professional rehabilitation organized by the labour authorities, focus on the maintenance of working capacities and health. When vocational guidance and work is given for the employment office clients, their health conditions and aspects influencing their working capacities are always considered. The health-related compatibility and the impacts on the working capacities are evaluated in a target-oriented manner with the unemployed looking for work or with the vocational guidance client. In 1995, there were about 14,500 disabled clients in vocational guidance, 60 % of whom obtained a vocational training plan and about 20 % an employment plan. There were about 60,000 disabled persons looking for work, and 35,000 of them had either work or training, or 10 % more than in the previous year.

As the labour force is aging, the need for vocational rehabilitation is growing, and so is the importance of these services for maintaining the health and working capacities of the labour force. The Finnish employment programme for 1996-1999 has set the objective of promoting the professional training and employment of the disabled.

Occupational health and labour protection

Besides the prevention of accidents at work, occupational diseases and work-induced diseases, increased attention has been paid to the actions aiming at maintained working capacities, with a special focus on the coping of the aging employees in changing working conditions. The objective is to encourage voluntary actions at the workplaces focusing on the prevention of musculoskeletal diseases as well to promote awareness of labour protection issues. The promotion of mental labour protection includes issues such as minimizing the threat of violence at work and problems of those working alone.

4.6.10 Ministry of Defence

Traffic accidents during the time off constitute the most important cause of death among the conscripts. To decrease the number of these fatalities, the Ministry of Defence implemented in the end of the 1980s and beginning of the 1990s the measures proposed by the Conscripts' traffic safety work group (1988), appointed by the Ministry. In virtue of the available information, it was considered that the most effective measure was to diminish the use of the soldiers' own vehicles, promoting the public transports in stead. The number of traffic fatalities among the conscripts has started to decrease in the 1990s, but promoting traffic safety among the conscripts remains a valid challenge.

The health promoting training consists of teaching which is necessary for avoiding the health risks in the special conditions of the military service, or health education promoting health, safety and functional capacities during the service as well as long-term health education in view of promoting health during the later phases of life. Good health of the conscript soldiers - including those in the reserve - is important for the defence.

The health education programme also includes first-aid training and practice. The teaching focuses on first aid in emergency situations. The recommendations of the manual "Health and functional capacities", used as supporting health teaching material, have undergone a thorough reform in 1995. All conscripts receive the booklet in the beginning of their service, and they can keep it after being discharged.

Suicide is the second most frequent cause of death among the conscripts. Mental health reasons account for about 60 % of the causes of interrupted service. The reasons contributing to the discontinued service were analyzed in 1990. To improve the management of these situations, a programme was launched, consisting of measures aiming at improved mental health screening during conscription and improved capacities of the superiors in preventive mental health work. The mental health manual intended for the use of the superiors was revised in 1995.

The work to prevent the spreading of intoxicant abuse was intensified in 1995-1996. The anti-drug health education material written for conscripts was revised, and so were the instructions for their superiors as well as the professional material for the use of physicians.

After the three mental health reasons, asthma is the most frequent physical reasons for discontinued service. In late 1995 and early 1996, the allergy work group II of the Defence Forces proposed various kinds of measures to improve allergy containment in the Defence forces. It was, among other measures, proposed that woolen blankets should be rapidly replaced. The work group also proposed that the water damaged buildings should be repaired and the damages caused by mould should be restored.

January 1996 saw the publication of the revised volume of the extensive Military health care manual, a result of the collaboration of 140 experts. The manual is intended for the physicians as their good practice instruction manual in their work for the health care and treatment of conscripts and for the evaluation of their health conditions.

5. Future Challenges for Health Policy

The principal trend in public health remains favourable, and this trend must be promoted. Under the pressure of the 1990s, health policy and health care have undergone changes and the operations have been developed so that the main functions are carried out with smaller resources. The foundation pillars of health care have not been questioned.

However, there are many problem areas in which the objectives have not been met. The disparities in health between the population groups show no tendency of diminishing. The results fall short of the objectives as regards the promotion of the functional capacities of the middle-aged and elderly population, and the situation is unsatisfactory by international standards. The intoxicant abuse problems are clearly becoming more serious. Health policy has not yet been fully adjusted to the great changes in the operative environment. Much thinking and new solutions are still needed to make the service system more purposeful, efficient and economical. All changes and accomplishments must be made in the framework of austerity budgets.

5.1 Promotion of equity in health

During the past few years, Finland has not been able to bridge the health differences between the various social groups and regions although this has been one of the principal objectives of health policy. However, the disparities in health between the sexes have diminished to some extent, even if they remain quite large by international standards. The growing differences between the income brackets, the extensive long-term unemployment and the difficulties in public economy may widen the gap between the social groups, in particular.

Increased information

Although a certain contribution has been made to describe and analyze the health disparities between various population groups, a lot of new knowledge is needed to orient more efficient measures. The health science committee of the Academy of Finland has in 1996 launched the preparation for a research programme on equity in health. The research institutes under the Ministry of Social Affairs and Health will intensify their research related to these issues.

Social policy promoting equity

The health disparities between various population groups are mainly based on the differences in their living conditions and in their intellectual and material resources. Therefore they can be influenced through consistent long-term social policy, labour policy and education policy measures which aim at diminished differences and give special consideration to the most disadvantaged groups. In 1996, an operative programme in preventive social policy was launched. Stronger market economy and growing competition may contribute to increased equity /// also in health. The social and health impacts of the reforms in other sectors of policy, such as education, need to be understood. In reforming the labour legislation, it is important that the position of the least well-off employee groups be improved.

Equity in health services

The municipal service system is one of the cornerstones of equal need-based services. I has not been shown that the current user charges would have to any significant extent prevented the necessary use of the services but some problem areas have been identified. In Finland, the patients' share of the health service payments is higher than in other EU countries. A special problem is constituted by dental health care where the year of birth 1956 divides the population into those entitled to government subsidized charges and those who must pay full price.

Despite the cost balancing mechanisms included in the systems, the expensive specialized health care services may be less available to the inhabitants of small municipalities. There are regional differences in the service system treatment practices. The use of services supported by the sickness insurance is quite unevenly distributed. The rapid structural change in mental health care services has lead to a situation where the disadvantaged patients are today worse off as regards the availability

of services. When the service system and its funding are being developed, special attention must be paid to the equal need-dependent supply of services.

The risk factors can be best reduced through health education and information among the well educated population, a fact that widens the health gap. Acting on the risk factors through social policy measures, such as the statutory smoke-free rule in places of work, is most beneficial to the most disadvantaged population groups. If risk factors are to be reduced, additional contributions must be made not only to health education but also to social measures improving the living environment and conditions.

5.2 Promotion of health of the young

Although the state of health of the young has shown a favourable general trend, many risk factors can be seen which may have serious consequences both in the short and in the long run.

Problems related to unemployment

Many young people face a history of long-term employment, having an impact on their mental and psychosocial health. The health of the young long-term unemployed must be an object of special concern. It is also important to help them find sensible substance for their daily life as well as to support and promote their leisure activities.

Prevention of intoxicant addiction

The lack of perspective, long-term employment and the opening of the borders have contributed to the increase in the narcotics and intoxicant abuse. At the same time, the municipalities have allocated significantly less resources for the treatment and prevention of these problems. To contain this situation, more resources must be given to both local and national prevention and to treatment. During 1996, a narcotics committee is preparing a proposal for a national narcotics programme.

Enhancing health education

The young have constituted a permanent target group for health education. By international comparison, the Finnish young start smoking at a very early age. In this area, the reformed Tobacco Act gives new possibilities to protect the health of the young. The implementation of the Tobacco Act calls for active work and unanimous collaboration between the health care system, the schools, the commerce and the other operators in the field. Health should be a quality factor on all levels of the school system. This idea can be promoted by creating the quality criteria of the health-promoting school. To support the municipal health education and to intensify the use of the national resources, the generation of centres with health education expertise is promoted through financial means.

Promotion of sexual health

For the young in Finland, starting their sex life does not involve problems. The number of teenage pregnancies and frequency of sexually transmitted diseases are diminishing owing to the determined health education carried out by the health care system and the schools. However, the rapid increase in the occurrence of sexually transmitted diseases in Finland's eastern and south-eastern neighbouring countries, as well as the increased HIV infection risk in the tourist countries favoured by the young present a serious threat. Commercial sex and the related problems have also increased. To prevent these problems, a report with proposals for measures has recently been given by a work group representing various sectors of administration. The growing minorities may also present new difficult challenges for the health education in this sensitive area. The promotion of sexual health therefore means that additional resources must be given to the development of professional expertise. To fight sexually transmitted diseases, financial obstacles to come to examinations and treatment must be eliminated.

The young and the service system

Students are encompassed by the systematic student and school health care mechanisms and the working young are treated by the occupational health care system. No instance takes similar long-term responsibility for the young who do not belong to these two categories, and often they are the ones with the greatest needs. The health care service must be given more resources to be able to care for all young people on a constant and long-term basis. The child welfare clinics must be developed to respond to the need of promoting the health of young families.

5.3 Improving the functional capacity of the population

Comprehensive prevention of wide-spread common diseases

For years, many health policy strategy documents have emphasized that priority should be given to functional capacity instead of adding years to life. Life-threatening

diseases have been the basic concern both in prevention and in treatment. Due to the reduction of functional capacity, the musculoskeletal diseases and the mental health disorders cause significant economic losses. The input made in their prevention is not in proportion to these losses. A comprehensive action programme is presently being prepared for the prevention of musculoskeletal diseases. The report on mental health (1996) is a step further in the national promotion of mental health work. The prevention of accidents at work and during leisure should get more resources.

Encouraging health promoting exercise

It is a social policy and cooperation challenge to encourage health promoting exercise among the middle-aged and elderly population. The target of the Fit for Life project, organized jointly by various administrative sectors, is constituted by the physically passive people. To meet the objective, a less competitive exercise culture should be created, and the conditions for exercise during normal daily activities should be improved. The aim of the cycling policy programme designed in 1993 by the Ministry of Transport and Communications is to promote the use of the bike in daily short-distance commuting, doubling its use by the year 2000.

Rehabilitation

A report has recently been given on the reform of the rehabilitation legislation. The Advisory Committee for Rehabilitation has made a proposal for a national action programme. All objectives of the reform have not been met although the system has been developed. The budget cuts have cause significant reductions in certain activities, mostly in mental health rehabilitation. Rehabilitation must be developed in view of the future social security and service system costs management. As the population is aging, the increase in rehabilitation need is inevitable.

Development of the working life

In the beginning of this decade, a working condition committee made a thorough analysis of the development of working life. This development work is continued within the framework set by the EU. Adapting the requirements of work to the working capacities of the aging labour force presents a major challenge. Questions pertinent to mental health and the sensible substance of the work itself have become increasingly important factors as concerns the premature discontinuation of the working career. The working places and the health care system must cooperate in promoting the maintenance of working capacities

Promoting the autonomy of the elderly

To keep up the functional capacities and autonomy of the elderly, it is vital to develop their living environment and social support given to them. Restructuring their living environments and introducing new technologies which support their autonomy constitute effective social investments. A report by the Old Age Policy committee was given in 1996.

5.4 Development of the service system

Pressures for change

The solid basic structures of the Finnish system are shown by the fact that the system has managed the severe economic depression without any major deterioration in the availability of the services. The future organization of the health care system must also be based on financing through tax-derived public funds and it must be dimensioned according to the public resources. Municipalities are responsible for organizing the services. People living in Finland have equal rights to get the services, regardless of their domicile or economic standing.

However, many social changes impose a pressure to change the financing and organizational structure of the system. Such factors include the austerity of the public economy, the small size of the municipalities, the rapid progress in technology and informatics, the great regional and municipal variation in the treatment practices and costs seen in the service structure, the more frequent local solutions and experiments in health care, the aging population, the disparities in the morbidity of different population groups, the financing through many channels, Finland's membership in the EU, and the regulations concerning the status of the clients.

Funding

Health care must continue to be financed through public funding. The is no justification for an obligatory insurance-based system. Such a system would separate the financing of health care from that of social welfare, a factor that would jeopardize the coordination of health care and social welfare. Moreover, international experience has shown that it is an expensive alternative and potentially unjust from the point of view of the private citizen.

The multi-channelled public financing system needs to be made more comprehensible and less complicated. As concerns the development of the municipal services, it is very important how the sickness insurance system and occupational health care system are going to be developed. Regardless of the fact that many large

southern Finnish municipalities have numerous private medical and occupational health care services, the cost of municipal health care is often above average in these municipalities. Different models of financing must be studied further. It is especially important that the financing promotes preventive work and community services. The balancing of the large-scale costs between the municipalities needs further consideration.

Organizational models

Since the reform of the state subsidy system and the legislation related to specialized health care, the role of the hospital districts has become somewhat blurred. Some districts see themselves mainly as providers of services, others think that the district are representatives of the municipalities. If the district assumes the role of the provider of the services, the counterpart must be a strong, expert buyer. However, the municipalities are often small and scattered, and they are not in a good position to negotiate.

The regional cooperation of the municipalities in health care needs further consideration and new solutions. These solutions need to promote the cooperation between health care and social welfare. They must also include an efficient system for balancing the cost of expensive treatment in order to prevent inequality.

Primary health care

The federations of municipalities organized for municipal primary health care continue to be dismantled. This creates the problem of an increasing number of new small units which find it difficult to maintain sufficiently versatile primary services. On the other hand, they improve the potential for cooperation with the social welfare.

Occupational health care provides the primary services for a significant share of the working population. The strengths of occupational health care include the great emphasis on preventive work and the easy availability of the services. The financial basis, and therefore also the direction of the operations, differ from the municipal primary health care. According to the studies made, the input of resources in occupational health care within a municipality is often not reflected as a decreased need for resources in municipal primary health care. It is therefore necessary to further study the financing and management principles as well as the coordination of the systems from an overall economic point of view.

The position of the clients

The position of the clients is determined by the fundamental rights regulations and by the international conventions, such as the Council of Europe social charter. When discussing the obligation of the public authorities to provide sufficient social and health services to all, special consideration should be given to the most disadvantaged groups, including those with mental health or intoxicant abuse problems.

The important right to choose the doctor or the place of treatment is not always materialized in the municipal service system. The so-called treatment guarantee models should be studied and experimented to secure rightly timed and correct treatment.

During the economic depression, the user charges have been raised, but no additional health care funding can be generated through them. Increases would have a great importance for the clients but very little effect on the overall economy of health care. In many individual cases the charges might be quite high, thus limiting the use of the necessary services. Therefore it is important that the introduction of the so-called comprehensive user charge limit be studied. The user charge limit would include the costs incurred by a family for all short-term health care services.

5.5 Coordination of the national health policy

Development of the national control

In the 1990s, the largest changes in the operative environment of national health policy have been caused by the central government reform and the new structure of the state-municipality relationship. The municipalities have gained much more importance as health policy operators. According to the objectives set, the reform has improved the efficiency and economy of the service system but deficiencies can also be observed. Many municipalities have short-sightedly reduced the resources allocated to preventive work, and certain parts of the service system have been curtailed so much as to increase problems

Previously, the National Board of Health gave detailed instructions on the operative substance of health care, showing the ways to act. The current information-based direction is based on the premise that the local operators and professionals are able to adopt the innovations on their own initiative and to develop the operation without superior administrative control. The support will be provided by information systems which will guarantee comprehensive information. Sometimes operative reform calls for extensive strategic changes, reform of the structures and delegation models. In such

cases strong national direction is needed for the implementation of the reforms.

The preparation of problem-oriented operative programmes calls for the cooperation of experts, the principal operators and those responsible for the use of the resources. The programmes can be prepared on the basis of the current delegation models, without returning to the old normative state authority system. Instead of administrative ordinances, the implementation of the programmes is based on joint commitment. National action programmes play a key role.

Health-targeted social policy

A meticulous study of the economic benefits of preventive work, as well as allocating the costs incurred as a result of disease to the instance having the prevention potential, will lead to efficient preventive work. For example, economic factors have constituted an important motor for the work safety reform. As concerns health care in general, purposeful preventive work is not sufficiently supported by economic mechanisms.

Municipalities and their health care have the principal responsibility for preventive work whereas the social insurance bears the heaviest cost for the unsuccessful prevention of many widespread common diseases. The economic impact of prevention and the respective allocation should be looked at in detail, and such studies have already been launched. It must at the same time be studied whether the financial systems can be developed to give increased incentive for preventive work.

The EU convention has given the Union the obligation to consider health protection in all sectors of policy. The Commission has started to follow the implementation of the objectives through the annual reports. In Finland the reform of the fundamental rights emphasizes the rights related to the citizen's health, but there is no such obligation involving the different administrative sectors as in the EU. It should be studied whether legislative measures could be useful for promoting the health approach in the decision-making of the various administrative sectors on the national and municipal levels.

The development of comprehensive national health policy calls for stronger national inter-sector cooperation structures. The management team of the Health for All programme prepared in 1991-1995 a health policy strategy and operative programme whereby the major operators of the various social sectors made a individual and joint commitment to the implementation of the programme. The programme follow-up has shown that the commitment by the supreme decision-makers is a good guarantee for the implementation of the agreed objectives. Target-oriented and comprehensive cooperation in health policy is still needed.

Prerequisites for municipal health policy

Municipalities have extensive competence in health policy. The trend after the state subsidy reform has been mainly positive. However, it is clear that all municipalities, especially the small ones, cannot have all necessary expertise. It is a major responsibility of the Ministry of Social Affairs and Health to see that the municipalities formulating their health policy are given the optimal support. This can be realized by orienting the operations of the health sector expert organizations in the sense of increased cooperation, by promoting the development of other centres of health expertise and by supporting the generation and activities of cooperation networks. A key role is played by on-line information systems which also provide municipality-level information.

Public Health Advisory Committee

The establishing of a Public Health Advisory Committee is being planned, with the task of coordinating the comprehensive health policy and preparing the operative programmes. The advisory committee would consist of the principal health policy operators from various administrative sectors and levels. It would be assigned the task of developing health policy and promoting its implementation. The advisory committee would get high-level experts together to work in divisions for the preparation of the programmes in each sector. This way the advisory committee would continue the work of the Health for All programme management team, filling the lacuna which the central government reform left in the national expert control. The first task of the advisory committee would be to revise the Finnish health strategy hand in hand with the WHO strategy to be reformed in 1998.

5.6 Strengthening of the international operations

Active EU policy

Finland's membership in the EU had some influence on the conditions for implementing a national health policy. The Union is not competent in matters concerning the health service system while many social policy decision, which influente health and the prerequisites of health, are made at the Union level. Some issues which in Finland are the competence of health administration

(drinking water, chemicals, foodstuff hygiene, pharmaceuticals policy, recognition of the professional degrees) are treated by different EU policy sectors.

In her EU policy, Finland must insist that in all social policy work maximal consideration should be given to health issues, as stipulated in the article on health policy of the Maastricht Treaty. The areas in which Finland's national policy has lead to good results, now threatened by Union policy, are particularly important. In the EU, alcohol policy and nutrition policy are seen as merely commercial and agricultural policy issues whereas Finland insists on their health dimension. An integral part of her EU policy, Finland should follow the implementation of the resolution underlining the health aspect in all sectors.

The work in divisions preparing the Finnish standpoints for the EU council decision-making constitutes the platform for introducing the health issues in the major sectors of policy. A sufficiently active approach is not achieved through the present practice. It would be important to set special health policy objectives for the various long-term policy sectors. They would constitute the foundations for the Finnish operative strategy and tactics in various councils and committees of the Commission.

Although the Union is not competent in service system matters, the community legislation has in the long run a profound effect on the health care operations through the free movement of goods, services and work force. As regards the national premises, the confidence of the small countries can also be undermined by ideological pressure. The defence of the Nordic welfare ideology in the EU calls for continuous development of those ideas. The reform of Nordic cooperation, orienting its health care functions in a spirit of active interaction and development in the EU environment, provides vital support for Finland's national policy.

Increased cooperation with the neighbouring regions

Finland has been resolutely creating information exchange and cooperation systems with the neighbouring areas to diminish the environmental health risks, radiation included, and to prevent the communicable diseases. For example, the seriously deteriorating communicable disease situation in Russia (diphtheria, tuberculosis, sexually transmitted diseases) has hardly been reflected in Finland.

As borders have become less controlled, the movement of intoxicants across the border has created much more serious problems. Import limitations and the related monitoring are measures which must be used in an efficient manner. It is important that the neighbouring countries are actively supported in their efforts to contain these health risks. In general, decreased health risks and improved health situation would also be reflected in Finland. Therefore it is justified that Finland increases the resources allocated to health-oriented cooperation with the neighbouring countries.

Mapping of Health Status in Finland 1996

The purpose of the Public Health Report is to give a compact overview of the prerequisites and actual state of health of the Finns, as well as of the major health challenges and trends. The aim of the report is not to cover all the aspects of health but to highlight the principal challenges and potentials in the foreseeable future.

One of the success stories is the 60 % decline in the heart disease mortality since 1970. It highlights how systematic work on all the aspects of a public health problem can result in major health gains. A change towards healthier eating habits, a decline in smoking among men, and improvements in the treatment of hypertension and acute heart situations have all been essential. Other successes are being recorded in dental health, cancer, AIDS and sexual and reproductive health.

The success stories also encouraged us to study the dark side. Why is the number of deaths from accidents higher than in the neighbouring countries? What is behind the surge in diabetes in children? Why does alcohol use cause a disproportional number of deaths in young men? What should be done to improve mental health? Disparities between different regions and population groups is identified as the major health problem.

A survey of the past health policy documents the well-known Finnish Health for All approach. A major section of the Report is devoted to studying the health impact of the policies in other fields than health. The contribution of other ministries to health is duly recognized and their participation in the promotion and protection of health is encouraged.

Guidance for Future Policies

The Report concludes by presenting some principal challenges for the immediate future. The future-oriented part covers a period of 2 to 4 years because the report will be given every two years. In practice, the action proposals given in the Public Health Report will be carried out until the end of this century. The principal conclusions are grouped under six headings.

Promotion of equity in health
Promotion of health among the young
Improving the population's functional capacity
Development of the service system
Coordination of public health policy
Strengthening of international cooperation

The Public Health Report will be discussed by the Committee of Social Affairs and Health of Parliament. The discussions will provide the Government with information as to how Parliament evaluates the success of past health policy, and it will give guidelines for its future development. The report and the parliamentary discussion on it also aim at opening health policy for public debate. The public discussion will help the municipalities and other health actors to modify their health policy and action towards common national goals.